EAST TENNESSEE AMBULATORY SURGERY CENTER, LLC

701 Med Tech Parkway
Johnson City Tennessee 37604
423-283-7302

Patient Label

Pre-Admission form to be filled out by patient

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ **M** ☐ **F**	**DOB:**

Marital status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Physicians: (List all of your personal physicians including Primary Care, Cardiology, Neurology, Pain Management, Orthopedic, etc.)

Physician Name	Address/City, State	Phone Number	Date of Last Visit

HEALTH AND SAFETY NEEDS

Assistive Devices/ Home Medical Equipment	☐ Oxygen ________liters ☐ CPAP ☐ BIPAP ☐ Upper Denture ☐ Lower Denture ☐ Partial Denture
	☐ Walker ☐ Cane ☐ Crutches ☐ Prosthetics ☐ Mobility Limitations (include neck/back): ☐ Home Health, Agency:
	☐ Glasses ☐ Contact Lens ☐ Hearing aids: ☐ Left ☐ Right
Social Needs Personal Safety	☐ Lives with spouse, significant other, or adult who can provide care to patient after procedure.
	☐ Lives alone, List person to provide care after procedure:________________________________ Contact number:_______________________________
	☐ Has no one available to provide care after procedure.
	☐ Home Health/Agency Referral Requested ☐ MD Notified:__________________________ Date:____________ Time:____________
Alcohol	☐ Yes ☐ No Do you need assistance to stop drinking alcohol?
	☐ Yes ☐ No Referral to Agency requested (AA, Support Group, Counselor)
Tobacco	☐ Yes ☐ No Do you need assistance to quit using tobacco?
	☐ Yes ☐ No Date:______ Time_______ Physician Name_________________ Patient Primary Care Physician notified of need for assistance
Substance Abuse	☐ Yes ☐ No Date:______ Time_______ Physician Name_________________ Patient PCP notified of need for assistance ______
Mental Health	☐ Yes ☐ No Do you have any Psychiatric illness requiring treatment? Describe :
	☐ Yes ☐ No Do you have any Mental Health concerns or issues? Describe:
	☐ Yes ☐ No PCP notified of patient needs, if applicable. Physician_____________________________Date_____________Time______________
Advance Directive	☐ Yes - Please provide copy; if unable where is a copy ____
	☐ No

Nurse Notes

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REVIEWED BY: PREADMISSION NURSE SIGNATURE: ____________________________DATE: ____________________

*********Patient MUST have someone remain at Surgical Center during procedure*****

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