BOOKLET PRE-OPERATIVE QUESTIONNAIRE (DAY)HOSPITALIZATION

Last name	
First name	
Date of birth	
E-mail	

Dear Sir/Madam

You will soon be admitted to the AZ Monica hospital for a procedure, test, or treatment. You received this booklet during your doctor's visit. We ask that you please read this booklet carefully and fill out the questionnaire. This enables us to prepare for your stay and improve the quality of our care.
Use this booklet, together with our general brochure, as a guideline for your hospital stay.
Please bring the completed booklet to the hospital on the day of your admission, pre-operative consultation, or pre-operative tests.

In addition to this booklet, you will receive several information leaflets and/or forms. You can also find these documents on our website: **www.azmonica.be**. You can also contact your treating physician-specialist for more information.

AZ Monica has two campuses. Before your procedure, test or treatment, always check at which campus you are expected:

- ○ **Campus Antwerpen**
  Harmoniestraat 68
  2018 Antwerpen
  T 03 240 20 20

- ○ **Campus Deurne**
  Florent Pauwelslei 1
  2100 Deurne
  T 03 320 50 00

Booklet completeness		
Admission H&P: OK – not OK	**Medication schedule:** OK – not OK	**IC Treatment and blood:** OK – not OK
Procedure H&P: OK – not OK – NA	**IC General:** OK – not OK	**IC Anaesthesia:** OK – not OK

Preparing for your admission

I. PRE-ADMISSION TESTS

Pre-operative tests are a necessary part of the preparation for surgery. What tests are required depends on your age, the type of surgery and your health. You, your treating physician or your general practitioner (GP) can find the tests required in the overview on the website www.azmonica.be > anaesthesia webpage > pre-operative tests or using the direct link/QR code.

QR code

There are 2 options for scheduling pre-operative tests:

Option 1 Your treating **physician** determines what tests or consultation(s) with a specialist are required in your case and gives you the prescriptions for these tests or consultations. During business hours, you will need to call the **hospital** for an appointment for these tests/consultation(s) at the following number:

- Appointments Campus Antwerpen: **T** 03 240 28 01
- Appointments Campus Deurne: **T** 03 320 50 05

We do recommend that you schedule any consultations with physician-specialists (for example cardiologist, pulmonologist, etc.) with your regular physician-specialist, even if they do not practice at our hospital. After all, your own physician-specialist knows your case and is therefore best positioned to help prepare for your admission. If you are not currently being seen by a physician-specialist, our specialists are ready to help you. You can schedule an appointment by calling the above-mentioned phone numbers.

Option 2 Your treating physician refers you to your **GP** for pre-operative testing. Your GP will then ensure that the required tests are performed. Contact your GP on time and schedule the appointment with your GP at least 2 weeks before your admission. Further down in this leaflet you will find a page for the GP to fill out (called 'information GP', see p. 13 and 14) which you can ask your GP to complete during the consultation. You can also review the medication overview and the other questionnaires with your GP if you prefer.

IMPORTANT!
If you prefer to have the tests performed by your GP or a physician-specialist who does not practice at AZ Monica, please bring all test results and reports on the day of your admission and for the pre-operative consultation with the anaesthesiologist. It is of the utmost importance that all information is available during the consultation with your anaesthesiologist and care providers. If you do not bring this information, your procedure, test, or treatment may be postponed.

II. PRE-OPERATIVE CONSULTATION IN THE ANAESTHESIA DEPARTMENT

A pre-operative anaesthesia consultation is possible but not always required; for example, when you are in good general health and you only have to undergo minor or intermediate surgery.
However, a pre-operative consultation is **necessary** under the following circumstances:

- You answered 'yes' to at least one of the 5 questions from the checklist for pre-operative assessment (see p. 9 in this leaflet under 'Procedure H&P).
- Your treating physician or your GP considers that a pre-operative consultation is necessary.
- You prefer visiting an anaesthesiologist prior to your surgery.

There are 3 options for scheduling this pre-operative consultation:

- Your treating physician schedules your consultation in the pre-operative consultation planner (Ultragenda).
- Your treating physician, your GP or you yourself call the hospital for a pre-operative consultation during business hours **using the same contact information mentioned above**.
- If no pre-operative consultation took place, for whatever reason, but is still required, you may, by exception, be visited by the anaesthesiologist in your room between the time of admission and the time of surgery.

If you have any additional specific anaesthesia-related questions, you can contact the departments via:

- Anaesthesia Campus Antwerp: **T** 03 240 22 78 **E** secranesthesieca@azmonica.be
- Anaesthesia Campus Deurne: **T** 03 320 60 66 **E** secranesthesiecd@azmonica.be
  T 03 320 56 43 (= anaesthesia CD office)

Do make sure that you have completed this pre-operative leaflet as much as possible before making your way to the pre-operative consultation and that all pre-operative tests have been performed (so please bring any results of pre-operative tests performed outside of the hospital).

III. PRE-OPERATIVE HOME MEDICATION POLICY AND PRECAUTIONS FOR MEDICATION WHICH MAY INFLUENCE COAGULATION

If you take any medications, especially if you take medications which may influence coagulation, you may be required to stop taking these medications and sometimes replace them with different ones. You, your treating physician, or your GP can find all information on this topic on the website www.azmonica.be > anaesthesia webpage > pre-operative tests or using the direct link/QR code.

QR code

IV. SOCIAL SERVICES

Each hospital department has a social worker or social nurse. You can always ask to speak to somebody from social services. This service is provided for free.

- Social services Campus Antwerpen: **T** 03 240 20 20 **E** socialedienstca@azmonica.be
- Social services Campus Deurne: **T** 03 320 50 00 **E** socialedienstcd@azmonica.be

V. ADMISSIONS SCHEDULING

Please call the scheduling department between 2 PM and 4 PM the day before your admission.
Do not hesitate to call the admitting department if you have any questions regarding room choice, the time of the procedure or if you want additional information. If you have to cancel your admission, please notify us in time.

- Scheduling department: **T** 03 320 50 08
  mon – fri 07.30h – 16.00h

  Exceptions: If you are admitted for ophthalmological surgery, contact the office of the eye clinic before your admission.
- Eye clinic Office: **T** 03 320 50 20

VI. HOSPITAL INSURANCE

Contact your hospital insurance provider or mutual insurance provider before you are admitted to the hospital and inform them about your admission.

Day of admission

I. ARRIVAL IN THE HOSPITAL

Bring along this booklet as well as the following items:

- ○ Results of any pre-operative tests that you had performed
- ○ Your electronic ID card
- ○ Blood type card (if you have one)
- ○ Allergy card (if you have one)
- ○ Letter of referral from your physician and any medical documents
- ○ Hospital insurance information
- ○ Debit cards to pay any advance payments or estimated costs.
  Please note! If you are insured by a Belgian mutual insurance provider, you only need to pay an advance payment of € 440 if you are admitted to a single room and are staying overnight. If you are not insured, a cost estimate will be drawn up.
- ○ The medication bag with medications that you use, in their original packaging
- ○ Toiletries (e.g. washcloths, toothbrush), underwear, possibly dressing gown, comfortable clothing, slippers (preferably with closed heels and non-skid soles). However, this is not required for day admissions
- ○ Any medical devices required: glasses, hearing aid, crutches, walker, etc.
- ○ If you own one of the following items and they are needed for your procedure, please bring your compression stockings (TED stockings), abdominal bands, spica bandages, braces, etc.

II. FASTING RULES

If, during your admission, you undergo surgery or a test/treatment under sedation, you must be fasted:

<table>
<tr><th></th><th>Volwassenen</th><th>Kinderen</th></tr>
<tr><td>6 hours before the procedure</td><td rowspan="2">• No solid food
• No smoking
• Allowed: clear, non-fizzy drinks (e.g. still water, sugar water, clear apple juice, tea/coffee without milk) > Max. 1 small glass/cup per hour</td><td>• No solid food
• No bottle-feeding
• Allowed: breastmilk, still water, clear apple juice) > Max. 1 small glass/cup per hour!</td></tr>
<tr><td>4 hours before the procedure</td><td>• No solid food
• No bottle-feeding
• No breastmilk
• Allowed: still water > Max. 1 small glass/cup per hour!</td></tr>
<tr><td>2 hours before the procedure</td><td>• No solid food
• No beverages
• No smoking</td><td>• No solid food
• No bottle-feeding or breastmilk
• No beverages</td></tr>
</table>

IMPORTANT! You **must** comply with these guidelines for general anaesthesia and locoregional anaesthesia or sedation. Not complying with these guidelines may endanger your life and will cause your procedure or test to be postponed!

Exceptions:

If you are admitted for a procedure under **local anaesthesia**, with or without mild sedation, you **do not have to be fasted**.

III. PRIOR TO THE PROCEDURE (only if you are undergoing surgery)

Regarding **hygiene**, please note the following:

- Remove all nail polish and gel nails, and make sure your fingernails are short and clean.
- Remove piercings.
- Before your admission, take a bath or shower. (Unless your treating physician instructs you otherwise, regular soap will suffice.) Pay special attention to any skinfolds (armpits, groin area, etc.) and do not forget your bellybutton. Wash your hair with regular shampoo. Also brush your teeth.
- Preferably have your dentist treat cavities and tooth abscesses in advance.
- Notify your physician if you are suffering from any infections.

Additional **points of attention**:

- Leave your jewellery, watch and other valuables at home. If you are carrying jewellery and/or piercings when you arrive at the OR, these will be removed, which increases the risk of these items getting lost.
- Leave your dentures, glasses, contact lenses, hearing aid, hair pins, combs, etc. in your room.
- Remove all makeup: It is important for your physician to be able to evaluate the colour of your face and lips during the procedure.

IV. AFTER THE PROCEDURE (only if you are undergoing surgery)

- We recommend that you do not drive any vehicles (car, moped or bicycle) or operate machinery after the procedure.
- We recommend that you do not go home alone and to make sure that a responsible person accompanies you home.
- We recommend that you are supervised by an adult for 24 hours after the procedure and that you are not home alone the first night after the procedure.
- We recommend that you do not take any important decisions and not sign any (legal) documents for 24 hours after the procedure.

PATIENT

PRE-ADMISSION H&P

QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

Please fill out this questionnaire carefully.

Last name ____________________
First name ____________________
Date of birth ____________________

Is there any RELEVANT INFORMATION relating to your current treatment or procedure? Are there any important elements in your MEDICAL HISTORY?

____

____

Is your IMMUNE SYSTEM compromised or has it ever been compromised? ○ Yes ○ No

If yes, please explain: ____________________

Are you ALLERGIC to certain substances? If yes, indicate the substances below and your reaction to them: ○ Yes ○ No

○ latex: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ rubber: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ adhesive bandages: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ disinfectants: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ anaesthetics (dentist): ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ medication
○ Penicillin: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ contrast: ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
○ other: ________ ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
____

○ other: (for example: food products, colorants, plants, pollen, trees, animals, dust mite, etc.)
________ ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________
________ ○ rash ○ shock ○ shortness of breath ○ fever ○ itching ○ hives ○ other: ________

Your PHYSICAL INFORMATION

Do you have any of the following medical devices? ○ pacemaker ○ ICD (= internal defibrillator) ○ (neuro)stimulator
If you indicated any of the devices above: Since ______ /______ /________ *and bring the identification card*
Your weight (kg): ________
Your height (cm): ________
Did you lose a significant amount of weight in the past 3 months? ○ Yes ○ No
If yes, what was the cause? ________

Only for FEMALE patients

Are you pregnant? ○ Possibly ○ Yes ○ No | Are you currently breastfeeding? ○ Yes ○ No

Your HABITS

Are you a smoker? ○ Yes ○ No If yes, ________ per day
Did you use to smoke, but have you quit smoking? ○ Yes ○ No If yes, ________ years ago
Do you consume alcohol? ○ Yes ○ No If yes, ________ glasses per week
Do you regularly use drugs or other substances? ○ Yes ○ No If yes, which? ________
How frequently? ________

FALL RISK assessment

Was a fall the direct cause for your admission to the hospital? ○ Yes ○ No
Do you sometimes have problems with your eyesight and/or balance? ○ Yes ○ No
Do you have to go to the bathroom frequently? ○ Yes ○ No
Are you over 65? ○ Yes ○ No

Your LANGUAGE and EDUCATION

Do you speak a language other than Dutch at home? ○ Yes ○ No; If so, which language? ________ Do you understand Dutch? ○ Yes ○ No
Please write your education: ________ Occupation: ________

Screening INFECTION CONTROL

In the past 3 weeks, have you been in: ○ Middle East ○ Central or West Africa
Over the past 6 months, have you spent more than 24 hours in a hospital, psychiatric institution, prison or refugee camp ○ Yes ○ No
Are you actively working as a livestock farmer or veterinarian ○ Yes ○ No
Do you work in healthcare and come into contact with patients ○ Yes ○ No
Are you staying in a residential care facility ○ Yes ○ No
Over the past 6 months, have you spent more than 24 hours in a hospital abroad ○ Yes ○ No
Do you live abroad, or have you just moved to Belgium in the past 12 months ○ Yes ○ No

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Screening INFECTION CONTROL

Are you or were you once a carrier of hospital bacteria (MRSA, CPE, VRE, etc.) ○ Yes ○ No
Are you over 75 ○ Yes ○ No
Do you regularly visit the hospital for a specific condition and/or treatment ○ Yes ○ No
Do you currently have an open wound ○ Yes ○ No
Have you received home nursing services over the past year ○ Yes ○ No
Do you have a contagious/communicable disease ○ No ○ Yes, please specify: ____

Your EMERGENCY CONTACTS and HOSPITAL STAY INFORMATION

Your emergency contact: ____ Relationship: ____ tel.: ____
Your emergency contact: ____ Relationship: ____ tel.: ____
Your general practitioner: ____ tel.: ____

You live: ○ at home ○ in an assisted living facility (service flat)
○ in a residential care facility ○ other: ____
Social status: ○ living alone ○ cohabitating, with ○ partner ○ children ○ other: ____
Marital status: ○ unmarried ○ married ○ legally cohabitating ○ divorced ○ widowed
Do you receive help at home? ○ Yes ○ No *(if yes, please fill out the table below)*

Relationship	**Who** (name)	**To be reached at** (tel.)	**Frequency** (times per week)
Home nursing service			
Family/senior citizen aid			
Physiotherapist			
Meal service			
Cleaner			
Others			

PHYSICAL assessment

Do you require assistance? ○ Yes ○ No

If yes, indicate below to which extent assistance is required for the activities listed below:

Bathing: ○ assistance required ○ independent
Grooming (face, teeth, hair and shaving): ○ assistance required ○ independent
Getting dressed and changing clothes: ○ assistance required ○ can do approximately half independently ○ independent
Stool: ○ incontinent ○ sometimes incontinent ○ continent
Urine: ○ incontinent ○ sometimes incontinent ○ continent
Toilet use: ○ assistance required ○ minimal assistance required ○ independent
Transfer (from bed to chair and back): ○ impossible ○ a lot of assistance required ○ minimal assistance required ○ independent
Mobility: ○ cannot move from one place to another ○ independent in wheelchair ○ can walk if assisted ○ independent, possibly using device
Taking stairs (up-and-down): ○ impossible ○ with assistance ○ independent
Eating: ○ assistance required ○ assistance required for cutting and making a sandwich ○ independent

DIET

Are you on a specific diet? If so, please indicate which below: ○ Yes ○ No
○ vegetarian ○ sugar-free (diabetics) ○ gluten-free ○ kosher ○ halal ○ other: ____
Do you have problems swallowing? ○ Yes ○ No

Please indicate which ASSISTIVE DEVICES you use ○ Not applicable

Mouth: ○ dentures top ○ dentures bottom
Ears: ○ hearing aid left ○ hearing aid right
Eyes: ○ contact lenses ○ glasses

Other: ○ artificial nails ○ piercings
Other: ○ crutches ○ walker ○ walking frame ○ wheelchair
Other: ____

Your SPIRITUALITY

○ I am religious, and/or I have a specific faith, more specifically: ____
○ I am not religious or prefer not to say it.
Would you like one of our spiritual workers to contact you during your hospital stay? ○ Yes ○ If necessary ○ Definitely not

PATIENT

This questionnaire was filled out carefully:
○ Independently ○ together with GP
○ With assistance from family ○ other: ____

Date creation questionnaire: ____ / ____ / ____

Signature:

WARD

To the admitting nurse in the ward:
○ The questionnaire was reviewed in full with the patient

Date: ____ / ____ / ____

Name (in full): ____

Ward: ____

PRE-PROCEDURE H&P

QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

To be completed **only** if you are undergoing a procedure/test

Last name ______
First name ______
Date of birth ______

Plannede procedure: ______ left / reight / both / NA
Age: ______ years Weight: ______ kg Height: ______ cm

CHECKLIST for PRE-OPERATIVE ASSESSMENT, to be completed only if you undergo general anaesthesia

Question	Yes	No
Are you short of breath after minor physical exertion?	○ Yes	○ No
Do you have chest pain or tightness in the chest after physical exertion?	○ Yes	○ No
Do you have cardiac arrhythmias – a pacemaker – coronary artery stents/bypass?	○ Yes	○ No
Do you have insulin-dependent diabetes?	○ Yes	○ No
Do you have any other illnesses other than those for which you are getting surgery that severely restrict your daily activities?	○ Yes	○ No

IMPORTANT! If you answered 'YES' to one or more questions, you must see the anaesthesiologist before the surgery. The options for scheduling a pre-operative consultation can be found at the beginning of the booklet under 'pre-operative consultation with the anaesthesiology department' on page 2 and 3.

Please complete the following questions carefully. These questions are for **all** patients undergoing a procedure, regardless of the type of sedation or anaesthesia that will be used.

Previous SURGERIES or experiences

Have you had surgery before? If yes, when and which surgeries: ○ Yes ○ No
Year: ______ Procedure: ______
Year: ______ Procedure: ______
Year: ______ Procedure: ______
Year: ______ Procedure: ______
Did the sedation cause you any problems (anaesthesia)? ○ Yes ○ No
If yes, please describe your reaction below: ______
Please indicate whether you frequently suffer from: ○ nausea ○ vomiting ○ motion sickness

CARDIOVASCULAR diseases

Do you have problems with your blood pressure? If so, ○ high blood pressure ○ low blood pressure ○ Yes ○ No
Are you receiving, or did you receive treatment for heart disease? If so, please mention which ○ Yes ○ No
○ Cardiac insufficiency ○ myocardial infarction ○ bypass ○ coronary artery stents ○ cardiac arrhythmias
○ Mitral valve stenosis or insufficiency ○ aortic valve stenosis or insufficiency ○ other valvular disease: ______
○ pacemaker > since ____/____/______ *(+ please bring pacemaker identification card)*
Are you still seeing a cardiologist? ○ Yes ○ No
If yes, name: dr. ______
Are you short of breath? If yes, ○ at rest ○ after minor physical exertion ○ Yes ○ No
Do you sometimes have chest pain or a feeling of tightness in the chest? If yes, ○ at rest ○ after minor physical exertion ○ Yes ○ No
Do you sometimes suffer from swollen feet or legs? If yes, when: ______ ○ Yes ○ No
Are you receiving, or did you receive treatment for vascular disease? ○ Yes ○ No
Do you have varicose veins? ○ Yes ○ No
Have you ever had phlebitis? ○ Yes ○ No
Are you taking medication for your blood pressure or your heart? If yes, include them in the medication overview ○ Yes ○ No

PULMONARY and RESPIRATORY diseases

Have you ever had a severe lung disease? If yes, please indicate which: ○ Yes ○ No
○ TB ○ pneumonia ○ other: ______
Do you have ○ asthma ○ hay fever ○ chronic bronchitis ○ COPD? ○ Yes ○ No
If you are taking any medications for these conditions (including aerosol and inhalers), please include them in the medication overview.
Are you receiving oxygen therapy? If so, how much? ______ O_2 L /min ○ Yes ○ No
Are you using a nasal CPAP machine? *If so, please bring your machine when coming to the hospital* ○ Yes ○ No
Do you currently have a cold or the flu? ○ Yes ○ No

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RENAL diseases

Do you suffer from kidney disease? If so, please indicate which: ○ Yes ○ No
○ renal insufficiency ○ kidney stones ○ kidney infection ○ other: ______

GASTROINTESTINAL and LIVER diseases

Are you receiving treatment for stomach disease? If so, please indicate which: ○ Yes ○ No
○ stomach ulcer ○ acid ○ reflux ○ oesophagitis ○ Crohn's disease ○ colitis ulcerosa ○ other: ______

Have you ever had jaundice or other liver diseases? If so, please indicate which: ○ Yes ○ No
○ hepatitis A ○ hepatitis B ○ hepatitis C ○ cirrhosis ○ other: ______

ENDOCRINE diseases (hormone system)

Do you have diabetes? If yes, please answer the following questions: ○ Yes ○ No
Indicate which type: ○ juvenile diabetes ○ adult-onset diabetes
Who checks your glycaemia (blood sugar) and when? ______
Are you insulin-dependent? ○ Insulin-dependent ○ not insulin-dependent
If insulin-dependent, who injects the insulin? ______

Do you suffer from a thyroid disease? If so, please indicate which: ○ Yes ○ No
○ hypothyroidism ○ hyperthyroidism ○ other: ______

NEUROLOGICAL diseases

Are you receiving treatment for a neurological disease? If so, please indicate which: ○ Yes ○ No
○ epilepsy ○ Parkinson's disease ○ migraine ○ other: ______
Are you receiving treatment for ○ a depression ○ aggression ○ attention disorder? ○ Yes ○ No
Have you ever had a brain bleed or thrombosis? If yes: ○ CVA (stroke) ○ TIA ○ Yes ○ No
If yes, which consequences are you experiencing? ○ speech problems ○ paralysis ○ sensibility problems ○ other: ______
Do you have a neurostimulator? ○ Yes ○ No
Are you suffering from a form of dementia? ○ Yes ○ No

BLOOD and COAGULATION

Do you continue to bleed long after a tooth extraction or injury? ○ Yes ○ No
Are you on blood thinners? ○ Yes ○ No
If so, include them in the medication overview and discuss with your GP, treating physician or anaesthesiologist..
Do you have a known coagulation disorder? If yes: ______ ○ Yes ○ No
Have you ever had a blood transfusion? ○ Yes ○ No
Have you ever had a reaction to a blood transfusion (transfusion reaction)? ○ Yes ○ No

ONCOLOGICAL conditions

Have you ever been treated for cancer? ○ Yes ○ No
If yes: type of cancer: ______
Treatment: ______
Have you had a sentinel lymph node dissection? If yes: ○ left ○ right ○ Yes ○ No

MOTOR SYSTEM diseases

Have you ever been treated for rheumatism or osteoarthritis? ○ Yes ○ No
Have you ever been treated for back or neck complaints? If yes, which: ______ ○ Yes ○ No
Do you have issues opening your mouth? *'yes'= you cannot put 2 fingers on top of each other between your teeth.* ○ Yes ○ No

OTHER diseases

Are you receiving treatment for an eye disease? If yes, which: ______ ○ Yes ○ No
Do you have relatives with congenital, hereditary conditions or illnesses? ○ Yes ○ No
If yes, which: ______

Other additions or COMMENTS

______
______
______
______

PATIENT

This questionnaire was filled out carefully:
○ Independently ○ together with GP
○ With assistance from family ○ other: ______

Date creation questionnaire: ____ / ____ / ______

Signature:

WARD

To the admitting nurse in the ward:
○ The questionnaire was reviewed in full with the patient

Date: ____ / ____ / ______

Name (in full): ______

Ward: ______

PATIENT

Medication overview: HOME MEDICATION

// TO BE COMPLETED BY THE PATIENT
(Preferably checked by GP)

STEP 1 Write down all medications that you take **daily** or **regularly** in this table. Do not hesitate to ask your physician-specialist, GP, or pharmacist for help. Do not forget to include blood thinners, cholesterol medications, diabetes medications, sleeping pills, painkillers, cortisone, hormonal preparations, medication for upset stomach, eye and ear drops, nutritional supplements, inhalers, ointments, medication patches, herbs, and injections.

STEP 2 Put this medication in its original packaging in the medication bag and bring along the table and bag when you are admitted to the hospital. This allows us to recheck your medication. When you arrive at the ward, you will hand over the bag and it will be returned to you when you are discharged from the hospital.

FILL IN

Do you receive help for preparing and/or taking your medication? ○ Yes ○ No

Have you recently (< 3 months) stopped taking any medication (e.g. antibiotics, cortisone, etc.)? ○ Yes ○ No If yes, which: ____________________

Are you taking any medication? ○ Yes (please fill in the overview below) ○ No (it is not necessary for you to fill in the overview below)

NAME OF THE MEDICATION	DOSAGE e.g. 5 mg, 250 mg/5 ml, ...	FORM e.g. tablet, drops, syrup, ...	FREQUENCY van het geneesmiddel neemt u en WANNEER?				FREQUENCY e.g. When fasted, every 2 days, 1x/ month, as necessary,	To be completed by the physician: If the medication is to be stopped prior to admission to the nursing unit: Time last taken
			MORNING	AFTER-NOON	AT NIGHT	BEFORE BED		
Example medication	5 mg	tablet	1	1/2	1		monday and thursday	

To be completed by the physician or GP - Medication to be started:

STARTING DATE	NAME OF THE MEDICATION	STRENGTH	FORM	HOW MUCH + TIMING?

PHYSICIAN OR GP

Surname and name: ____________________

Date: _____ /_____ /________

Stamp + signature

Information General Practitioner

FOR THE GENERAL PRACTITIONER

Dear General Practitioner,

Using the overviews on AZ Monica's GP portal (link: **https://huisarts.azmonica.be**), you can check which pre-operative tests are required, based on age, type of procedure and ASA classification. In addition, you can see which precautions to take regarding your patient's medication. You can also directly navigate to these 2 documents using the links and QR codes on page 2 and 3 of this booklet.

If your patient is admitted for a procedure under **local or topical** anaesthesia, please request additional tests based upon your own clinical judgment.

If necessary or if preferred, your patient can see the anaesthesiologist for a pre-operative consultation. If necessary, please also refer your patient to an organ specialist for additional evaluation. For more information, please see page 2 and 3 of this booklet.

IMPORTANT! The patient is requested to bring all results and medical information (including your clinical findings) to the anaesthesia consultation or their admission. Tests which are older than 30 days must be repeated upon admission if there are any significant clinical changes. It is of the utmost importance that all information is available, if not your patient's procedure, examination, or treatment may be postponed. Please note that an ECG is valid for 6 months..

General questions

Patient has the following ASA classification	○ I ○ II ○ III ○ IV
Have all questionnaires been completed correctly and completely?	○ Yes ○ No
Has the medication overview, see page 11, been filled out (correctly) and signed?	○ Yes ○ No

Relevant medical information / H&P

____

____

____

____

Relevant information from the preparatory clinical examination

Cardiac/haemodynamic: ______________________________

Respiratory: ______________________________

Abdomen / Gastrointestinal: ______________________________

Urogenital: ______________________________

Neurological: ______________________________

Orthopaedic / Locomotor system: ______________________________

Other: ______________________________

Preparatory technical examinations performed

ECG	◯ Yes ◯ No	Findings:	
Chest X-ray	◯ Yes ◯ No	Findings:	
Lab	◯ Yes ◯ No	Findings:	
Specific tests[1]	◯ Yes ◯ No	Findings:	

1 Please perform a MRSA screening if the patient has tested positive before or if the patient is currently staying in a residential care facility or nursing home.

Informal care: After their hospital stay, the patient can

Return home (private address)	◯ Yes ◯ No
If yes, do they have to arrange for home care?	◯ Yes ◯ No
If yes, of which type? ____________________	

GENERAL PRACTITIONER

Date: ______ /______ /__________

Stamp + signature:

Statement of consent // General

Dear patient,

Please read this statement of consent thoroughly and confirm it upon your admission to our hospital.

I, the undersigned, ______________________________ (surname, name),
in my capacity of patient / parent/ legal representative (delete which does not apply) of patient:
______________________________ (surname, name)
declare to have read the general statement of consent as described below, that I have understood it and that I approve.

I am aware that since 2002, patients have legally defined rights in Belgium, which also apply to me during my hospital stay. In addition, I am aware that I also have duties as a patient and that I am partly responsible for my care. By complying with these duties, I contribute to a respectful relationship with my healthcare providers and I enable them to provide me with the best possible care. More information on patient rights can be found on www.patientrights.be or in our leaflet 'Your rights and duties as a patient'.

I will correctly and fully inform my care provider at all times about my identity, health condition and medication use. I will follow the advice of my health care providers and I collaborate with the treatment to which I have agreed. In the hospital, I do not take any medication at my own initiative without discussing this in advance with my healthcare providers. If I have an advance directive, I will inform my healthcare providers about this so that they can keep this in mind.

I am aware that interns and residents also participate in providing care, under supervision.

If I need to undergo a high-risk procedure, my treating physician will inform me about this and ask me to provide a specific informed consent (using a document that I sign). This is the case for e.g. blood transfusions, different types of anaesthesia and diagnostic or therapeutic procedures.

If I wish to leave the hospital against the advice of my treating physician, I will inform my physician of this and I will sign a statement of 'refusal of treatment'. The same applies to any other treatments suggested I do not wish to undergo at this time.

I will comply with the general agreements as they apply in AZ Monica:

- No smoking in the hospital. Just outside the hospital there are areas where smoking is allowed.
- The visiting times determined by the hospital will be observed. These can be found in the welcome brochure, on the website or on posters in the hospital. During visits, I do not cause any nuisance or excessive noise.
- No sound or image recordings may be made inside the hospital.
- I consent to my patient information being processed anonymously as part of national and international scientific research. I agree that the hospital supplies this anonymous data to the government or other research institutions in order to obtain statistical information about our healthcare.

I consent to my patient information being processed anonymously as part of national and international scientific research. I agree that the hospital supplies this anonymous data to the government or other research institutions in order to obtain statistical information about our healthcare.

I consent to my information being stored in a central medical record on an electronic exchange network or hub. In this way, all the relevant information about my care and treatment is accessible to all my healthcare providers within AZ Monica. This record can also be made available, if needed, to your GP or other healthcare providers in hospitals that treat you.
For more information, please see http://vlaamspatientenplatform.be/pagina/toestemming-delen-gezondheidsgegevens or www.antwerpseregionalehub.be.

> If you do **not consent** to storing your information on the hub, please **strike out** the above sentence.

PATIËNT
Date: ______ /______ /_________
Signature:

Statement of consent // Treatment

Dear (parent or representative of the) patient,

Please read this statement of consent thoroughly and indicate whether you consent or dissent and confirm this with your name and signature. You can reread all the information in the leaflet or on our website.

I, the undersigned________________________________ (surname, name), in my capacity of patient / parent/ legal representative (delete which does not apply) of the patient:
________________________________ (surname, name).

- Declare to agree with the **proposed procedure, examination, or treatment**, being:
  ________________________________ ◯ left ◯ right ◯ bilateral ◯ NA
  > If the above-mentioned procedure, examination, or treatment relates to the transplantation/donation of: ◯ ocular tissues ◯ locomotor system tissues I give the physician my permission to perform the above-mentioned procedure, examination, or treatment, and state that I have been given the opportunity to ask questions.
- I have received sufficient information on the risks, benefits and alternative options for this procedure, examination, or treatment. I have fully understood this information.
  I have received this information through the information leaflet/brochure and/or the website and/or verbal explanation.
- I give my consent to have anonymous images or pictures taken before/during/after the above-mentioned procedure, examination, or treatment which, similarly to the information from the record, may be used later for medical education or scientific publications.

◯ **Consent** to treatment – administration of **blood products** (if required)

- I declare to agree with the administration of blood products (i.e. packed cells, platelets and/or plasma).
  This administration will take place in the context of:
  ◯ a surgical procedure ◯ a nonsurgical procedure
- I have received sufficient information on the risks, benefits and alternative options for this procedure, examination, or treatment. I have fully understood this information.
  I have received this information through the information leaflet/brochure and/or the website and/or verbal explanation.
- I agree that this consent is valid for all subsequent (identical) procedures/treatments within the same hospital stay.

◯ **Refusal** of treatment – administration of **blood products**

- I declare that I do not give my permission for the administration of blood products under any circumstances, even if my care providers would deem this necessary for preserving my life or health. I am aware of the possible consequences of this decision and take responsibility for it.
  The reason for this refusal of treatment is: ________________________________

- I declare that I will observe all of the physician's guidelines. I realise that despite the best efforts and care on the part of the treating physician(s), the nursing team and myself, success cannot be absolutely guaranteed.
- I agree that in case of emergency, any and all measures may be taken to guarantee my safety/health.
  ◯ With the exception of:________________________________

PATIENT/PARENT/REPRESENTATIVE

Date: ______ /______ /_________ Time: ______________

Signature:

PHYSICIAN

Stamp + initials

Information leaflet // Transfusion of blood or bloodproducts

Annex to the statement of consent
for transfusion of blood or bloodproducts

WHAT is a transfusion of blood or bloodproducts?

A transfusion of blood or blood products is an intervention in which human blood or blood products (plasma, platelets, or other blood products) are administered to a patient.

OBJECTIVE of transfusion of blood or bloodproducts

Adding blood or blood products of which the concentration or amount in the patient is too low.

ADVANTAGES of transfusion of blood or bloodproducts

The deficiencies are rapidly updated so that the functions realized by this blood or blood products are quickly optimized. A blood transfusion is lifesaving in case of mass bleeding. There is an accelerated recovery in the absence of red blood cells.

RISKS of transfusion of blood or bloodproducts

Transfusion reaction, shivering, fever, infectious disease, sepsis.

ALTERNATIVE options of transfusion of blood or bloodproducts.

Fluid resuscitation, resting.

POINTS OF ATTENTION IN PREPARATION of a transfusion of blood or bloodproducts

A blood group should be determined; For transfusion of blood, a cross test must be performed.

POINTS OF ATTENTION AFTER a transfusion of blood or bloodproducts

Watch for the occurrence of a transfusion reaction (see Risks).

CONTACT DETAILS

Red Cross Flanders.

More information?
A detailed explanation regarding blood products can be found on the website of the Red Cross Flanders, more specifically https://www.rodekruis.be/dienstvoorhetbloed/bloedproducten/

DC1132 // Labo – Infofiche transfusie van bloed of bloedproducten EN // Versie april 2020

Statement of consent

// General anaesthesia
// Perioperative pain management
// Procedural sedation

Dear (parent or representative of the) patient,

Please read the following informed consent statement carefully and confirm it with your name and signature. You can re-read all the information on general anaesthesia and procedural sedation in the attached leaflet. Before administering the anaesthesia, the anaesthesiologist will re-read this statement together with you and will also sign it, to show agreement.

I, the undersigned, ______________________________ (surname, name),
in my capacity of patient / parent/ legal representative (delete which does not apply) of the patient:
______________________________ (surname, name)

- Agree to the proposed anaesthesia/pain management, i.e.:
  - ○ general anaesthesia
  - ○ plexus anaesthesia or peripheral nerve block
  - ○ peridural or spinal anaesthesia by means of an epidural
  - ○ parabulbar anaesthesia
  - ○ mild, moderate, or deep sedation
    in combination with ○ local anaesthesia
    ○ topical anaesthesia (drops)
- I have received sufficient information on the risks, benefits and alternative options regarding the proposed anaesthesia or sedation and any postoperative pain management. I have fully understood this information. I have received this information through the information leaflet/brochure and/or the website and/or verbal explanation.
- I have read all information about the pre- and post-operative guidelines and understood them, and I agree to comply with these guidelines..

I agree that in case of emergency, all measures should be taken to ensure my safety/health.
○ with the exception of: ______________________________

PATIENT/PARENT/REPRESENTATIVE

Date: ______ /______ /_________ Time: ______________
Signature:

PHYSICIAN

Stamp + initials

DC432 // Afdeling anesthesie – toestemmingsverklaring anesthesie EN // Versie april 2020

Information leaflet // General anaesthesia // Procedural sedation

Annex to the statement of consent for general anaesthesia, perioperative pain management and/or procedural sedation

In addition to all information on the other types of anaesthesia, you can also find this information leaflet on the Department of Anaesthesiology's website.

You can review this website directly at www.azmonica.be > anaesthesia webpage > pre-operative tests or using the direct link/QR code

QR code

WHAT is GENERAL ANAESTHESIA?

General anaesthesia involves (1) putting someone to sleep, i.e. temporarily rendering them unconscious; (2) administering painkillers to make sure you do not feel any or only mild pain after the procedure; (3) if necessary, administering muscle relaxants, to facilitate the surgeon's work. In some cases, the blood pressure is lowered too.

Before you are put to sleep, a catheter is inserted in a vein and an IV is connected. You are put to sleep by injecting all the necessary medication via this IV. During the procedure, your heart rate, blood pressure, oxygen level and sometimes also temperature are carefully monitored and managed. Following this, a mask is inserted in the throat, or a tube is put in the airway to safely continue with the general anaesthesia. Sometimes, local anaesthesia is added to the general anaesthesia in order to improve pain management after the procedure. After the procedure, you can "sleep it off" in the recovery room under supervision. When you are awake, and your pain is under control, you will be taken back to your room.

OBJECTIVE of GENERAL ANAESTHESIA

The objective of general anaesthesia is to render you, the patient, completely unconscious and pain-free.

ADVANTAGES of GENERAL ANAESTHESIA

The advantage of general anaesthesia is that you are not aware of the surgery, that you do not feel any pain (not even during major procedures) and that you do not remember the procedure afterwards. This makes sure your body does not experience as much stress during the procedure, which helps with the healing process.

In some cases, it may be safer to admit you to the hospital for a short period of time, even though you were scheduled for same-day surgery. This may be necessary if a surgery was more complex than planned of if there were problems with the anaesthesia. It is also possible that the anaesthesiologist may postpone the procedure due to urgent medical reasons (however, this is rare).

RISKS of GENERAL ANAESTHESIA

Even though anaesthesia is very safe these days, there are still risks and side-effects. These do not cause any permanent damage. They include, among other things, nausea, vomiting, sore throat, hoarseness, nosebleeds, minor lip injuries and dizziness. Other complications are more severe but are much less common. If you are healthy (no allergies, no cold, no flu, no heart problems, no bronchitis or asthma episode, etc.), we do not expect these complications to occur. Sometimes, respiratory problems occur, due to stomach reflux (1 in 10,000 cases); or tooth damage (1 in 30,000 cases). Very severe complications are very rare and include brain damage (1 in 80,000 cases) or sudden death (1 in 200,000 cases).

DC1115 // Afdeling anesthesie – Infofiche algemene anesthesie en procedurele sedatie en pijnstilling EN // Versie april 2020

ALTERNATIVES for GENERAL ANAESTHESIA

In most cases where general anaesthesia is suggested, there is clearly no alternative.
In a number of cases where general anaesthesia is suggested, the alternative (local or locoregional anaesthesia) is less comfortable for patients compared to general anaesthesia. Therefore, in the interest of patient comfort, the locoregional anaesthesia is supplemented with a milder form of general anaesthesia.
In some cases (adding) general anaesthesia or deep sedation is, in itself, a good alternative for local or locoregional anaesthesia.

Whether there is an alternative to general anaesthesia and what this alternative may be must be reviewed on a case-by-case basis, together with your treating physician and anaesthesiologist.

WHAT is PROCEDURAL SEDATION?

Sedation literally means lowering the level of consciousness to such a level that you feel sleepy and comfortable. This is done by administering sleep medication or sedatives. This is often combined with painkillers (analgesics). There are different levels of sedation, more specifically mild, moderate, and deep.
Sedation and analgesia are used for various procedures. More and more patients ask for sedation for procedures that they consider unpleasant or threatening. The most common procedures on adults involving sedation are endoscopy techniques such as intestinal exams (colonoscopy), stomach exams (gastroscopy), an ERCP, termination of pregnancy (abortion), fertility treatments (e.g. IVF), procedures in the ER (e.g. fractures) and treating cardiac arrhythmias using an electric shock. Ophthalmological procedures are often performed under mild sedation, so you can still follow the ophthalmologist's orders which enables them to easily perform the procedure (e.g. don't blink, look in a certain direction, etc.).
The physician performing the procedure or examination determines together with you whether sedation and analgesia are necessary. The sedation and analgesia are performed by the anaesthesiology department.
You will receive sedatives and/or analgesics before the procedure, test, or treatment through an IV. Medication is administered until you have reached the right level of sedation and analgesia. During the procedure, you will be closely monitored, to see how you react to the sedatives and/or analgesics. If necessary, the medication is adjusted. After the procedure, the administration of sedation is stopped. You will be taken to the recovery room. Here you will be looked after and monitored until you are fully awake.

OBJECTIVE of PROCEDURAL SEDATION

Many medical procedures cause patients pain, stress, and anxiety. Administering sedation and painkillers can prevent this so you feel comfortable and so the procedure does not bother you too much. This also facilitates the procedure. Sedation can vary from mild sleepiness (mild sedation) to deep sleep (deep sedation). The effect of the sedation depends on individual sensitivity, type of drug, method of administration and combinations of drugs that reinforce each other. For some procedures, we will choose a deeper sleep in order to make the procedure more comfortable.

ADVANTAGES of PROCEDURAL SEDATION

- The sedative lowers your level of consciousness: you begin to feel sleepy and drowsy. This means that you are very often not (fully) aware of the treatment. Sometimes you even forget what happened afterwards.
- The painkillers suppress pain stimuli: you feel less or no pain.
- Your reflexes, such as breathing and swallowing, remain intact. You can generally be roused. It is similar to sleeping. Therefore, you are not under general anaesthesia. Reflexes that protect your body, such as breathing, coughing, and swallowing are maintained. In general anaesthesia, the level of consciousness is so depressed that respiration and reflexes are suppressed which requires airway management.

RISKS of PROCEDURAL SEDATION

Applying sedation is generally safe in healthy patients. The following side effects are possible:

- You may feel nauseous. This is a side effect of the different medications.
- On occasion, you may have trouble breathing or experience a drop in blood pressure. That is why you are monitored during the procedure.

These events are easy to manage and rarely result in problems. That is why it is important for the staff member who is responsible for the sedation to assess whether you belong to a special population. This is assessed by asking a number of questions about your condition. He will also perform a physical exam, to check your heart, lungs, and airways. The staff member will discuss the risk assessment with you, allowing you to select, together, which type of procedural sedation & analgesia will be used during the procedure. People who are underweight or overweight or who have abnormalities of the head or neck region, chronic disorders of the heart and lungs or with previous negative experiences during a procedural sedation/analgesia or general anaesthesia have a higher risk.

ALTERNATIVE OPTIONS for PROCEDURAL SEDATION

If you, the patient, do not want any sedation (mild, moderate, or deep) or analgesia, there are currently no alternatives. Most procedures will then have to be performed without any sedation or analgesia. In some cases (e.g. ophthalmological procedures), it is possible to use a different type of sedation.
Whether there is an alternative to sedation and what this alternative may be must be reviewed on a case-by-case basis, together with your treating physician and anaesthesiologist.

Cost

General information regarding the cost of your procedure, examination, or treatment and the fee supplements which may be charged can be found on our website: www.azmonica.be. You will also find a price simulator for the most common procedures. For more information regarding the cost of your procedure, you can also contact AZ Monica's invoicing department (T 03 240 27 25 – daily between 9AM and 4PM).

Contact details

If you have any further questions, you can either raise them over the telephone or you can ask an anaesthesiologist to provide you with additional information upon your admission. Simple questions can also be discussed with your anaesthesiologist right before your procedure, examination, or treatment.

Campus Deurne
03 320 60 66 (department)
03 320 56 43 (secretarial staff)
secranesthesiecd@azmonica.be

Campus Antwerpen
03 240 22 78
secranesthesieca@azmonica.be

www.azmonica.be

AZ MONICA

Am I ready? // Admission checklist

- I have read the general brochure and completed this booklet.
- I have had all the necessary preparatory tests performed.
- I have all the reports and results of tests which were not performed in AZ Monica.
- I will bring all medications that I am currently taking to the hospital, preferably in their original packaging. I will use the medication bag. Not applicable for day admissions.
- I have arranged transportation to and from the hospital.
- I have informed my hospital insurance provider (or national health insurance provider) about my admission.
- There is someone who will be available when I return home to help me with practical matters.
- If I require any medical devices when arriving home (for example crutches), I have made sure that they are available.
- If I have questions for my attending physician, i will write them down.

campus Deurne
Florent Pauwelslei 1 // 2100 Deurne
T 03 320 50 00

campus Antwerpen
Harmoniestraat 68 // 2018 Antwerp
T 03 240 20 20

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