ADVANCED DIRECTIVE ACKNOWLEDGEMENT

Do you currently have a Living Will? YES _____ NO _____

Do you currently have a designated
Power of Attorney for Healthcare? YES _____ NO _____

If yes, Name _____

If you answered "YES" to any of the above questions, please sign your name at the bottom and bring a copy of your Living Will and/or POA to the Hospital.

If your copy is on file in the hospital, check here _____

If you answered "NO" to any of the above questions, go to Section 2.

SECTION 2

I, _____, have been given a copy of the Advanced Directive and have been informed of my rights in formulating a Living Will or Power of Attorney for healthcare.

(You will receive a blue pamphlet on Living Wills and POA's from the scheduling clerk or nurse.)

Patient Signature: _____

Witness: _____

Hopedale Medical Complex

Scheduled Procedure:

Date of Procedure:

Have you had any problems with Nausea after surgery? ☐ YES ☐ NO

Have you had any problems with your bowels after surgery? ☐ Constipation ☐ Diarrhea

Have you been hospitalized in the last 30 days? ☐ YES ☐ NO

Are you on Dialysis? ☐ YES ☐ NO

Have you had anything implanted in your body in the last 90 days? ☐ YES ☐ NO

If yes what type?

Have you ever taken any over the counter pain medications? ☐ YES ☐ NO

What works well for you?

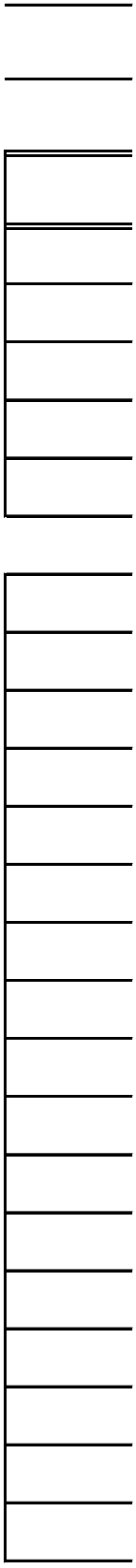
Have you ever been prescibed any Narcotics? Ie: Tylenol #3, vicodin, Norco? o YES o NO

What has worked well for you?

Are you currently on any pain medications over the counter or prescibed? Please list below:

Are there any pain medications you do not tolerate well? Please list below:

PATIENT ID



Hopedale Medical Complex
107 Tremont P.O. Box 267 Hopedale, IL 61747

Hopedale Medical Complex
107 Tremont Street
Hopedale, IL 61747

ENDOCARDITIS PROPHYLAXIS QUESTIONNAIRE

Patient Name: _____ D.O.B.:_____Date: _____

Physician: _____ Allergies:_____

SCHEDULED PROCEDURE:_____

1.	Does the patient have a prosthetic heart valve?	Yes	No
2.	Was the valve implanted within the past six months?	Yes	No
3.	Is there evidence of abnormality of the implanted heart valve?	Yes	No
4.	Has patient been treated for bacterial endocarditis in the past year?	Yes	No
5.	Does the patient have an active GI infection which could include Enterocoocus?	Yes	No
6.	Has the patient, within the last six months, had implantation of a pacemaker, vascular graft, vena cava filter, vascular stent or orthopedic implant?	Yes	No
7.	Does the patient have cirrhosis and GI bleeding?	Yes	No
8.	Is the patient having an ERCP?	Yes	No
9.	Is the patient having a percutaneous gastrostomy tube placed (PEG)?	Yes	No

Forward this information to the surgeon if any "Yes" answers are obtained to any question other than Question 1.

- ❑ Dr. _____ notified. **No** Antibiotic is required.

OR

- ❑ Dr. _____ notified. See Antibiotic order sheet.

_____

Staff signature Date

Hopedale Medical Complex

PATIENT'S CONSENT TO RELEASE PROTECTED HEALTH INFORMATION—ADULTS ONLY
Medical Records Department (309) 449-4286

ONGOING CONSENT FORM

PATIENT'S NAME (please print)**:**_____ **DATE OF BIRTH:**_____

PATIENT'S COMPLETE ADDRESS:_____

**The undersigned hereby authorizes use or disclosure of Protected Health Information (PHI), as described below, about the patient named above.*

Hopedale Medical Complex, including Hopedale Hospital, Hopedale Nursing Home, Medical Arts Physicians, Hopedale Pharmacy, Hopedale Wellness Center, Hopedale Commons and all its entities/employees are authorized to *use or disclose Protected Health Information (PHI)* about the patient. "PHI" includes individually identifiable information and medical records relating to the patient's health, healthcare provider, billing, insurance and demographic information.

The undersigned understands that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

The undersigned may revoke this authorization by notifying Hopedale Medical Complex Medical Records Department or the Chief Operating Officer. However, the undersigned understands that any action already taken in reliance on this authorization cannot be reversed, and a revocation will not affect those actions. The undersigned understands that HMC may not condition its treatment of the patient on whether or not this authorization is signed.

A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE GIVEN TO THE INDIVIDUAL OR OTHER SIGNATOR.

1. I, the patient of HMC, hereby consent to ***receive disclosure of*** **PHI** upon request for the duration of one year from today's date.
   [**DO YOU OFTEN REQUEST COPIES OF YOUR LABS, TESTS, AND OFFICE NOTES FOR YOUR PERSONAL RECORDS?]**
   - ☐ Yes, I wish to receive copies of my labs, tests, and office notes for my personal records
   - ☐ No, I do not wish to receive copies of my labs, tests, and office notes for my personal records

2. The following person(s) *are authorized to* ***receive disclosure of*** **PHI** about the patient. Please list name, address and phone:

   (a) _____ (b) _____
   _____ _____
   _____ _____

3. **I consent to disclose the following information upon request:**
   - _____ Lab Reports
   - _____ OPV (Outpatient Visit Form)
   - _____ Medication List
   - _____ Diagnostic Test Results/Reports
   - _____ Office Notes (does not include H&P reports, Discharge Summaries, etc.)

   UNLESS YOU INITIAL HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: _____ **YES, DISCLOSE THIS TYPE OF INFORMATION.**

4. This authorization **expires 1 year from today's date,** and will remain valid even if Patient becomes incapacitated following signature. If Patient wants authorization to expire sooner or upon some future event, indicate here:_____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. You agree to pay said invoice within 30 days.

THIS FORM MUST BE COMPLETED BEFORE SIGNING.

_____	_____	_____
Signature of patient (The person about whom the information relates)	**Date of signature**	**Date of Birth or Social Security Number**

OR, if applicable -

_____	_____	_____
Signature of Guardian or Personal Representative of Patient	**Date of signature**	**Description of Authority to Act for the individual (POA, Guardian, Executor)**

STOP BANG Questionnaire

Male/Female Age _____

Height _____ inches/cm Weight _____ lb/kg BMI ____

Collar size of shirt: S, M, L, XL, or _____ inches/cm

Neck circumference* _____ cm *(* **Neck circumference is measured by staff**)

1. **Snoring**: Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes **No**

2. **Tired**: Do you often feel *t*ired, fatigued, or sleepy during daytime?

Yes **No**

3. **Observed**: Has anyone *o*bserved you stop breathing during your sleep?

Yes **No**

4. **Blood Pressure:** Do you have or are you being treated for high blood pressure?

Yes **No**

5. **BMI**: *B*MI more than 35 kg/m2?

Yes **No**

6. **Age**: *A*ge over 50 yr old?

Yes **No**

PLEASE NOTIFY CARDIOPLUMONARY
IF SCORE IS GREATER THAN 3

7. **Neck circumference**: *>40 cm*

Yes **No**

8. **Gender:** *G*ender male?

Yes **No**

_____***High risk of OSA****:* answering yes to two or more in STOP **or**
answering yes to three or more items STOP-BANG COMBINED

_____***Low risk of OSA****:* answering yes to less than three items

Patient Identification

Nurse/Date:_____

ANES12.001
C:\Users\eharms\Desktop\STOP-BANG ANES12.001.docx

Adapted from: ***STOP Questionnaire*** ***STOP-BANG.docx***