

**CENTRAL STATE HOSPITAL
CONTINUITY OF CARE
AMBULATORY SURGERY NEXT DAY EVALUATION**

Date of Surgery _____ **Informant** _____

Client's Temperature: (oral) (rectal) (Other _____ **)** _____

Symptoms following ambulatory surgery:	Yes	No	Interventions:
1. Nausea or vomiting?			
2. Urinary retention?			
3. Decreased level of consciousness?			
4. Decreased activity?			
5. Abnormal bowel function?			
6. Cough?			
7. Breathing difficulty?			
8. Bleeding?			
9. Incision problem?			
10. Other? (Explain)			

Signature

Date

Stamp plate

**INSTRUCTIONS
CONTINUITY OF CARE
AMBULATORY SURGERY NEXT DAY EVALUATION
(CSH - 97)**

This form serves as documentation for a telephone call that will be made by the surgical nursing staff to the parent unit to document findings the day after surgery.

This form is to be imprinted with the stamp plate by the surgical staff on the day of the procedure.

1. **Date of Surgery:** enter the date the surgical procedure was performed.
2. **Informant:** enter the name of the nurse (RN/LPN) providing the information from the parent unit.
3. **Client's Temperature:** circle the route obtained and enter the temperature.
4. **Table:** The OR/ER nursing staff will obtain the response to questions 1-10 on the table from the nurse on the parent unit and check the appropriate column (yes/no). For item 10, list any other symptoms. **If any symptoms are answered yes, the surgeon/ER physician will be notified by the OR/ER nursing staff immediately.**
5. **Interventions:** note any interventions implemented to alleviate symptoms in the column allotted.
6. **Signature:** ER/OR nursing staff completing the form shall sign on the signature line.
7. **Date:** enter date information obtained.