Patient Name (Last, First, MI):
Patient DOD ID Number:
Patient Date of Birth:

DEFENSE HEALTH AGENCY
NATIONAL CAPITAL REGION

Patient Name:
(Last, First, MI)

PRE-OPERATIVE/PRE-PROCEDURE PACKET

Prior to being seen or contacted for your anesthesia prescreen, the following need to be completed:

1) Patient Registration Form

2) Surgical Consent

3) Blood Consent (optional)
- ☐ Type and Screen/Type and/or Cross ordered
- ☐ AF IMT 1225 for use at MGMCSC

4) Anesthesia Pre-op Questionnaire

5) Privacy Act Statement

6) Third Party Collection Program/Other Health Insurance, DD Form 2569 (only for non-active duty, completed every 12 months)

Surgery Location [check one]

☐ **FBCH**
dha.belvoir.fbch.mbx.apu-surgical-packets@mail.mil

☐ **KACC**
danielle.l.washington.civ@mail.mil; nancy.a.maloney.civ@mail.mil; blair.e.cooke.civ@mail.mil

☐ **MGMCSC** ☐ **SDS** ☐ **23:59**
usaf.jbanafw.316-mdg.mbx.preadmissions@mail.mil

☐ **WRNMMC**
dha.bethesda.j-11.mbx.wrnmmc-apu-pre-op-packet@mail.mil

CLINIC STAFF USE ONLY – MANDATORY

CLINIC PROVIDER NAME & CONTACT#:

☐ Is the patient currently undergoing disability evaluation? If yes, contact surgeon for required clearance documentation from chain of command.

☐ APU Preoperative Appointment for Anesthesia Appt Date:

☐ Appropriate for T-Con Surgery Date:

☐ Chart Reviewed and Complete

Staff Initials/Time/Date:

Patient Name (Last, First, MI):	
Patient DOD ID Number:	
Patient Date of Birth:	

This page is to be completed by APU staff, not for patient use

APU Deficient Tracking Tool

Date:	Deficit Code:	Service:	Physician:	Notes:

A: Incomplete forms
B: Pre-Procedure Testing missing
C: Missing Orders
D: Missing Content
E: No Essentris Chart/Orders
F: Wrong classification

Patient Name (Last, First, MI):
Patient DOD ID Number:
Patient Date of Birth:

PATIENT REGISTRATION FORM

(Please fill out this form completely)

Registration Clerk: Date:

Patient Information:

Name (Last, First Middle):

Sponsor's SSN: Your SSN: Sex: Select One

Patient DOD ID#: Religious Preference: DOB:

Ethnicity (check one): ☐ Filipino ☐ Hispanic ☐Southeast Asian ☐Asian/Pacific Islander ☐Other:

Race (check one): ☐Asian ☐Black ☐Western Hemisphere Indian ☐White ☐Other:

Marital Status (check one):☐Single ☐Married ☐Divorced ☐Other

Home Address:

State: Zip Code: Primary Phone: Secondary Phone:

For Active Duty: Are you currently undergoing disability evaluation through the disability evaluation system? ☐ Yes ☐ No

Emergency Contact Information:

Name (Last, First MI): Relationship:

Address:

State: Zip Code: Best Contact Phone:

Next-of-Kin Information: ☐ Same as Emergency Contact

Name (Last, First MI): Relationship:

Address:

State: Zip Code: Best Contact Phone:

Sponsor Information: ☐ Same as Emergency Contact ☐ Same as Next of Kin ☐ Same as Patient

Name (Last, First MI): PRP/PSP/Flying Status:

Service: Rank: MOS/Rate/AFSC

Command: Length of Service:

Duty Address:

State: Zip Code: Duty Telephone:

Other Health Insurance: *(Please do not include TRICARE)*

Are you covered by private health insurance: ☐Yes ☐No If Yes, notify Patient Administration (PAD)

I certify that the information on this form is complete and correct to the best of my knowledge.

Patient Signature Date

Patient Name (Last, First, MI):	
Patient DOD ID Number:	
Patient Date of Birth:	

DEFENSE HEALTH AGENCY
NATIONAL CAPITAL REGION

Pre-Surgical/Procedural Additional Information Form

Please use this space to fill out any additional information that was not able to fit on other forms.

Patient Name (Last, First, MI):
Patient DOD ID Number:
Patient Date of Birth:

Anesthesia Preoperative Questionnaire

Patient's Name: Last, First MI	**Age:**	**Sex:** ☐ Male ☐ Female ☐ Other	**Ht:** _____ in	**Wt:** _____ kg	STAFF USE BMI:
Sponsor's SSN:	**Rank:**		**Primary Phone:**	**Secondary Phone:**	

1. Do you have, have you ever had, or been told you had any of the following:

		Y	N			Y	N			Y	N
1.	Asthma	☐	☐	14.	Pacemaker and/or Defibrillator	☐	☐	27.	Thyroid Problems	☐	☐
2.	COPD/Emphysema	☐	☐	15.	Heart Stent	☐	☐	28.	Diabetes	☐	☐
3.	Home Oxygen Use	☐	☐	16.	Atrial Fibrillation	☐	☐	29.	Bleeding Disorder/Low Blood Count/Anemia	☐	☐
4.	Recent Flu/Cold/Bronchitis	☐	☐	17.	Other Heart Disease/Chest Pain	☐	☐	30.	Post-Traumatic Stress Disorder (PTSD)	☐	☐
5.	Sleep Apnea ☐ Mild ☐ Moderate ☐ Severe	☐	☐	18.	Communicable Disease (e.g. HIV, Hep B, Hep C)	☐	☐	31.	Personal or Family History of Malignant Hyperthermia	☐	☐
6.	CPAP Use	☐	☐	19.	Stroke/TIA	☐	☐	32.	Psychiatric disease	☐	☐
7.	Significant Snoring	☐	☐	20.	Cancer	☐	☐	33.	Significant Disability	☐	☐
8.	Other Lung Disease	☐	☐	21.	Seizures/Epilepsy	☐	☐	34.	Born Prematurely	☐	☐
9.	High Blood Pressure	☐	☐	22.	Frequent Heartburn	☐	☐	35.	Developmental Delay/ ADD/ADHD	☐	☐
10.	Congestive Heart Failure	☐	☐	23.	Esophageal/Stomach Disease	☐	☐	36.	Allergies (Food, Medications, Latex)	☐	☐
11.	Heart Valve Problems	☐	☐	24.	Liver/Gallbladder/Pancreatic Disease	☐	☐	37.	Difficult Airway or Failed Intubation	☐	☐
12.	Heart Attack	☐	☐	25.	Kidney/Bladder Disease	☐	☐	38.	Multidrug Resistant Organisms (MRSA, VRE)	☐	☐
13.	Irregular Heartbeat or Heart Murmur	☐	☐	26.	Spinal/Back Problems	☐	☐	39.	*Females Only:* Any Gynecological Disease	☐	☐

2. Please explain any "Yes" answers with corresponding number above in detail. Use extra form if needed.

3. Do you have any specific concerns or questions regarding the anesthesia portion of your surgery? ☐ **Yes** ☐ **No**

If yes, please explain: _____

*** See reverse to complete questionnaire ***

For Administrative Purposes

Signature _____ Signature _____

APU Prescreen Personnel Anesthesia Provider

Revised JUN 2020

Patient Name (Last, First, MI):	
Patient DOD ID Number:	
Patient Date of Birth:	

Anesthesia Preoperative Questionnaire

4. Have you had any type of surgery or anesthesia before? ☐ Yes ☐ No.
If YES, please list the surgery, type of anesthesia (General, Spinal, Epidural, Local, Sedation) and any problems, if any, you had with anesthesia. Use extra form if needed.

YEAR	Type of Surgery/Procedure	Type of Anesthesia	Problem?

5. Have you taken any medication (prescription, over-the-counter, herbal/supplements) for any reason in the last 6 months? ☐ Yes ☐ No. If YES, please list those medications below. Use extra form if needed.

Medication	Dose	How Often?

6. Do you or have you ever used tobacco products to include cigarettes, cigars, vaping, and/ or chewing tobacco?
☐ Yes ☐ No. How many packs per day? ____ How many years? ____
If you stopped smoking, when did you quit? _____

7. Do you drink alcohol (beer, wine, liquor)? ☐ Yes ☐ No. If YES, how much and how often? _____

8. Do you use any recreational drugs (e.g. marijuana/THC/CBD, opioids, cocaine, etc..) ☐ Yes ☐ No.
If YES, what have you used, how much and how often?

9. Have you ever been hospitalized for ANY reason (other than surgery listed above)? ☐ Yes ☐ No.
If YES, please provide approximate dates and reasons.

10. Can you climb stairs? ☐ Yes ☐ No. If YES, how many flights? ☐ 1 ☐ 2 ☐ 3 ☐ 4
If NO, please explain:

11. FEMALES ONLY. Is there any possibility you could be pregnant? ☐ Yes ☐ No.
Date of last menstrual period. _____

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires 31 Aug, 2019

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected;1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment FacilityROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	**2. SSN**	**3. DATE OF BIRTH** *(YYYY/MM/DD)*

4a. MAILING ADDRESS *(Include ZIP Code)*	b. HOME TELEPHONE NO. ( )
	5a. FAMILY MEMBER PREFIX / b. SPONSOR SSN
6a. PATIENT'S EMPLOYER'S NAME	b. EMPLOYER TELEPHONE NUMBER

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

☐ a. **YES.** *(If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)*

(1) Member ID	(2) Plan ID	(3) Expiration Date *(YYYY/MM/DD)*

(4) VA Facility Name *(e.g., primary care/specialty clinic)* that assists in coordinating your care

(5) VA Facility Address and Telephone Number

☐ **b. NO.** *(Proceed to Item 8.)*

8. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)*

☐ a. **YES.** *(Complete Item 9 and the remaining sections below.)*

☐ b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 13.)*

☐ c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 12.)*

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n. (1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** *(Complete 11c.-f. and proceed to Item 13.)* ☐ b. **NO** *(Proceed to Item 13.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

12. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME
d. MEDICARE PART D NUMBER AND PLAN NAME		e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE

13. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.

e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYY/MM/DD)*

16. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

17a. SIGNATURE *(Patient or Adult Family Member)*	b. DATE *(YYYY/MM/DD)*

18. VERIFICATION a. (1) Date *(YYYY/MM/DD)*	(2) Initials	b.(1) Date *(YYYY/MM/DD)*	(2) Initials	c.(1) Date *(YYYY/MM/DD)*	(2) Initials

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. *(Check all applicable boxes)*				1b. DESCRIBE
☐	OPERATION OR PROCEDURE	☐	SEDATION	
☐	ANESTHESIA	☐	TRANSFUSION	

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

which is to be performed by or under the direction of Dr.

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are:

(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and signif icant alternative therapies.

(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | *(Signature of Patient)* | *(Date and Time)*

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)

sponsor/guardian of understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) | *(Signature of Sponsor/Legal Guardian)* | *(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no.(SSN or other); hospital or medical facility)*	REGISTER NO.	WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

OPTIONAL FORM 522 (REV. 7/2008)
Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)
DoD Exception to OF 522 approved by GSA

Patient Name (Last, First, MI):
Patient DOD ID Number:
Patient Date of Birth:

Patient Name (Last, First, MI):	
Patient DOD ID Number:	
Patient Date of Birth:	

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR	6. SOCIAL SECURITY NUMBER OR DOD IDENTIFICATION NUMBER OF MEMBER OR SPONSOR	7. DATE *(YYYYMMDD)*

BLOOD TRANSFUSION
PATIENT INFORMATION AND CONSENT FORM

Dear Patient,

During the course of treatment you may need to receive blood or blood products. You should feel free to ask your doctor why you may need a transfusion. Benefits of transfusion include: (1) to improve oxygen delivery to your organs, (2) to replace factors or cells that help stop bleeding, or (3) to provide proteins (called globulins) to help your immune system, or (4) other reasons your doctor will explain. While many precautions are taken to make blood products safe, there are some well-known risks, including but not limited to, those listed below.

1. **Transmission of infectious diseases: All blood for transfusion in the U.S. is tested for the following infectious diseases: HIV 1 & 2, HTLV I & II, Hepatitis B & C, syphilis, Chagas, and West Nile Virus. Only units that are negative for all of these tests are allowed to be transfused.** Although these tests are extremely sensitive, on very rare occasions, a unit will contain a low level of virus that cannot be detected with current testing methods. There are diseases for which no approved test yet exists or there may be infectious risks, as yet unknown to us, that could be transfusion-transmitted. There is no way to guarantee a zero-risk transfusion, however, research and development of more sensitive tests are ongoing. As better testing methods are introduced into the blood banking industry, it is possible that transfusion recipients could be contacted in the future by their blood bank for follow-up information or blood samples. Your cooperation, should this occur, would be completely voluntary, and your participation could contribute to improvement in the safety of the nation's blood supply.

2. Fever: Transfused blood products can cause fever in some individuals.

3. Allergic reactions: After blood transfusion a person may occasionally experience wheezing, itching, low blood pressure, swelling in the throat, or breathing problems.

4. Hemolytic reactions: A potentially serious reaction can occur if you receive a unit of blood that is of a different ABO type from your own. Even when ABO-compatible blood is given, delayed hemolytic reactions can occur if the transfused red blood cells stimulate your immune system to make antibodies against them a few days to weeks following transfusion. This usually causes the transfused red blood cells to be destroyed in your spleen, resulting in a mild temporary jaundice (yellowing of the skin).

5. Transfusion-related acute lung injury (TRALI): A potentially fatal reaction involving lung damage has been reported in some recipients of cellular blood products and fresh frozen plasma. This reaction is not well understood and is being actively studied. It is believed the reaction is related to either an agent in the blood of certain donors, particularly females who have been pregnant in the past, or an agent that accumulates in some units of blood as they age. TRALI is manifested by difficulty breathing and fever within 1 to 6 hours after transfusion. Most victims fully recover, but in some cases the reaction is severe enough to cause death.

The above complications are rare, but potentially life-threatening. The estimated risks of these complications are shown in the table on the next page.

6. **For surgical patients:** Under special circumstances, your surgeon may determine that it is necessary or desirable to use a technique called Intraoperative Red Cell Salvage. This technique uses specialized equipment that harvests and washes your lost surgical blood and prepares it for transfusion. Use of this blood is an effective means to reduce the use of banked blood, decreasing the likelihood of transfusion reactions and spread of infectious disease. Drawbacks to this method include the need for anticipated large blood loss volumes, non-applicability to all types of surgery, and the potential spread for certain types of malignancy.

Patient Name (Last, First, MI):	
Patient DOD ID Number:	
Patient Date of Birth:	

BLOOD TRANSFUSION
PATIENT INFORMATION AND CONSENT FORM

ESTIMATED RISKS OF SOME TRANSFUSION COMPLICATIONS

TRANSFUSION RISK FOR EACH UNIT RECEIVED	RISK	REFERENCES
Febrile reaction[1]	1 : 60[a]	[a] Estimated to be 1:91 with prestorage leukoreduction and 1:46 with poststorage leukoreduction.
Transfusion-associated circulatory overload (TACO)[2]	1 : 100[b]	[b] Indicates the estimated risk per recipient rather than unit.
Allergic reaction[3]	1 : 250	[c] The estimate is variable depending on the length of the infectious period.
Bacterial Sepsis (from platelets)[9]	1 : 2,000 to 1 : 3,000	[1, 2, 3, 4, 5, 6, 7, 8] – Clinical Practice Guidelines From the AABB Red Blood Cell Transfusion Thresholds and Storage, *JAMA*.doi: 10.1001/jama.2016.9185
Delayed hemolytic transfusion reaction[11]	1 : 2,500 to 1 : 11,000	[9] AABB Association Bulletin #14-04, 18 Jul 2014.
Transfusion related acute lung injury (TRALI)[4]	1 : 12,000	[10, 11] AABB Technical Manual, 18th ed., 2014
Acute hemolytic transfusion reaction[10]	1 : 76,000	
Hepatitis C virus infection[5]	1 : 1,149,000	
Hepatitis B virus infection[6]	1 : 1,208,000 to 1 : 843,000[c]	
Human immunodeficiency virus infection[7]	1 : 1,467,000	
Fatal hemolysis[8]	1 : 1,972,000	

The alternatives to transfusion include: (1) not receiving a transfusion, (2) pre-surgical autologous donation, and (3) intraoperative red cell salvage. If you have any questions about transfusion risks, benefits, complications, or alternatives, please discuss them with your doctor **BEFORE** you agree to have any blood transfusion.

1. COUNSELING PROVIDER OR DENTIST: I have counseled this patient as to the proposed procedure(s), attendant risks involved, the expected need for transfusion, and the use of intraoperative red cell salvage (if appropriate).

_____ _____ _____
Provider/Dentist Signature Date Time

2. PATIENT: I understand the risks associated with blood transfusion and the reasons why my doctor(s) may wish to transfuse me. Should my doctor(s) deem a transfusion necessary, I agree to be transfused. For surgical patients only - I understand that intraoperative red cell salvage will / will not (initial one) be used.

_____ _____ _____ _____ _____ _____
Witness Signature Date Time Patient Signature Date Time

3. PARENT/LEGAL REPRESENTATIVE: (When a patient is a minor or unable to give consent)
I, _____, parent/legal representative of _____, understand the nature of the proposed procedure(s), attendant risks involved, and the expected need for transfusion and red cell salvage (if appropriate). I hereby request that such procedure(s) be performed. Should the doctor(s) taking care of this patient deem a transfusion necessary, I agree with their decision.

_____ _____ _____ _____ _____ _____
Witness Signature Date Time Parent/Legal Representative Signature Date Time

Patient Identification		
	Patient Name (Last, First, MI):	
	Patient DOD ID Number:	
	Patient Date of Birth:	

INFORMED CONSENT FOR BLOOD TRANSFUSION

I acknowledge that I have discussed the risks of blood transfusion with my provider. I understand that there is a small but definite risk of potentially serious infectious disease transmission and/or other reactions. The Blood Transfusion Information Sheet (reverse of this form) lists possible complications of blood transfusion and their current (as of January 2004) reported risks of occurrence. If I do not feel well after my blood transfusion, I will notify my provider. I have read this information and I have been give the opportunity to ask my provider questions about this procedure.

I understand that the practice of medicine is not an exact science and that no process or testing is 100% reliable. I acknowledge that no guarantees have been made to me about the outcome of the transfusion.

The alternatives to transfusion, including the risks of not receiving this therapy, if needed, and the use of autologous transfusions have been explained to me.

I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form or the Blood Transfusion Information Sheet. I understand that I can withdraw this consent to the procedure at any time before the beginning of the procedure.

SIGNATURES

1. *I have counseled this patient as to the nature of the proposed transfusion(s), attendant risks involved, and expected results as described above and by your provider.*

_____ _____

COUNSELING PROVIDER SIGNATURE *DATE*

Complete either 2. or 3. below:

2. *I understand the nature of the proposed procedure(s) attendant risks involved and expected results, as described above, and hereby (request / refuse)* refuse *such transfusion(s) be performed.*

_____ _____

PATIENT'S SIGNATURE *DATE*

_____ _____

WITNESS SIGNATURE (Excluding members of the surgical team) *DATE*

3. *I,* _____ *sponsor/guardian of* _____ *understand the nature of the proposed transfusion(s) attendant risks involved and expected results, as described above and by your provider, and hereby* refuse *(request / refuse) such transfusion(s) be performed.*

_____ _____

SPONSOR / LEGAL GUARDIAN SIGNATURE *DATE*

_____ _____

WITNESS SIGNATURE (Excluding members of the surgical team) *DATE*

PATIENT IDENTIFICATION *(Typed or written entries: full name; FMP SSAN; grade; hospital or medical facility.)*	*REGISTER / HOSPITAL NUMBER:*
Patient Name (Last, First, MI): Patient DOD ID Number: Patient Date of Birth:	*WARD / CLINIC / UNIT NUMBER:*
	DATE:
	DISTRIBUTION: ☐ *Patient Medical Record (Permanent record)* ☐ *Executive Committee Copy (Optional)*

PRIVACY ACT STATEMENT - AUTHORITY: 10 USC 8013

The social security number provides positive identification for blood transfusions. Disclosure is voluntary; however, the procedure cannot be performed without your name, social security number, and signature.

Routine Use: This information may be disclosed to health providers.

BLOOD TRANSFUSION INFORMATION SHEET

During the course of your medical treatment, you may need one or more unit(s) of blood and or one of its products in the interest of your health and proper medical care. Blood products include whole blood, red blood cells, fresh frozen plasma, platelets, white blood cells, clotting factors, and cryoprecipitate. The benefits of such an infusion are very individualized and are best explained by your physician. While many precautions are taken to make blood products safe, there are some well-known risks, including, but not limited to, those briefly outlined below.

1. **TRANSMISSION OF INFECTIOUS DISEASES.** *Despite careful donor selection and testing of blood products for unexpected antibodies to Hepatitis B and C, antibodies and antigens for Human Immunodeficiency Virus (exposure to the virus causing AIDS), antibodies to HTLV-I and syphilis, the risk of infectious disease transmission or adverse recipient response cannot be completely eliminated.*

2. **METABOLIC COMPLICATIONS.** *Blood product infusions can lead to problems by causing changes in the body temperature or electrolyte (chemicals in the blood) balance.*

3. **BLOOD CLOTTING PROBLEMS.** *Receiving a large amount of blood products may dilute out more important elements that help blood clot. This may require transfusion of blood clotting elements.*

4. **FEVER.** *Transfused blood products can cause fever in a small number of people.*

5. **ALLERGIC REACTIONS.** *On occasion, a person may experience wheezing, itching, low blood pressure, swelling of the airway in the throat, or breathing problems after a blood transfusion.*

6. **HEMOLYTIC REACTION.** *A serious reaction that involves the destruction of blood cells can occur if you receive blood that is a different type from your own.*

Most of these complications are rare, but may be potentially life threatening. If you have questions about these or other possible complications, please address them to your provider.

RISKS OF A TRANSFUSION AND CHANCE FOR EACH UNIT RECEIVED

(Risks of transfusions as of January 2004)

ACUTE RISKS		*DEATH - ALL TRANSFUSION CAUSES*	*1:160,000*
Hemolytic reaction			
Acute hemolysis, fatal	*1:100,000*	*Acute hemolysis, nonfatal*	*1:40,000*
ABO incompatibility	*1:33,000*	*Transfusion - related acute lung injury*	*1:5,000 to 1:190,000*
Non-hemolytic reaction			
Allergic (Urticarial) transfusion reaction	*1:100*	*Acute anaphylaxis*	*1:20,000 to 1:50,000*
Febrile transfusion reaction	*1:3 to 1:200*	*Nonimmune hemolysis*	*Infrequent*
Volume overload	*less than 1:100*		
Chemical imbalance; Hypothermia; coagulopathy are Uncommon and mainly associated with massive transfusions			
Alloimmunization			
Platelet refractoriness	*1:10 to 1:100*	*Hemolysis*	*1:5,000 - 1:11,000*
DELAYED RISKS			
Hemolysis, delayed	*1:40,000*	*New antibody formation*	*1:100*
Graft-versus-host disease	*Rare*	*Post-transfusion purpura*	*Rare*
Hemosiderosis -- Dose related	*Unknown*	*Immune modulation*	*Unknown*
POTENTIAL DISEASE TRANSMISSION			
Bacterial infection			
RBC:	*1 in 500,000 red cells cause sepsis*	*1 in 5,000,000 units cause death*	
Platelets:	*1 in 13,500 random or apheresis platelets cause sepsis*	*1 in 67,000 of these platelets may cause death*	
	1 in 2,000 pooled platelet products cause sepsis	*1 in 16,130 pooled platelet products cause death*	
Viral infection			
Hepatitis C virus	*1:1,600,000*	*Hepatitis B virus*	*1:63,000*
HTLV - I & II	*1:641,000*	*HIV - I and 2 (and the AIDS)*	*1:1,900,000*
West Nile Virus:	*1:833 through June 2003.*	*NAT testing implemented June 2003 -- risk is expected to decrease.*	
Other Viruses (CMV, EBV, HAV, and Parvovirus B19)	*In selected Populations or rare*		

References:

Technical Manual, l4th ed., Bethesda Maryland, American Association of Blood Banks, 2002.

STATEMENT OF THE AMERICAN ASSOCIATION OF BLOOD BANKS BEFORE THE BLOOD PRODUCTS ADVISORY COMMITTEE, Blood Bags for Diversion of the Initial Collection, March 15, 2001, Presented by Louis Katz, MD, Chair, AABB Transfusion Transmitted Disease Committee.

American Association of Blood Banks, Bulletin 03-11, Update on WNV Related Activities and Recommendations, September 12, 2003.

Biggerstaff and Petersen, Estimated risk of transmission of the West Nile Virus through blood transfusion in the US, 2002. Transfusion Volume 43 Issue 8 Page 1.007, August 2003.

Kardon, Eric MD, Transfusion Reactions, eMedicine, August 24,2001, http://www.emedicine.com/emerg/topic603.htm .

Sandler, Gerald, MD, FACP, FCAP, Transfusion Reactions, eMedicine, January 5,2004, http://emedicine.com/qred/topic2297.htm

DEFENSE HEALTH AGENCY
NATIONAL CAPITAL REGION
Pre-Surgical/Pre-Procedural Instructions

Surgery Date: _____
Surgeon(s): _____

Location:

☐ **Fort Belvoir Community Hospital**
9300 DeWitt Loop
Fort Belvoir, VA 22060
Main: (571) 231-4185
APU check-in: Oaks Pavilion, 2nd Floor

☐ **Kimbrough Ambulatory Care Center**
2480 Llewellyn Avenue
Fort Meade, MD 20755
Main: (301) 677-8800
Same Day Surgery: 1st Floor, East Wing

☐ **Malcolm Grow Medical Clinic and Surgery Center**
1060 W. Perimeter Road
Joint Base Andrews, MD 20762
Main: (240) 612-4866/1152/1031
Same Day Surgery: 2nd Floor, East Wing

☐ **Walter Reed National Mil Med Center**
4494 North Palmer Road
Bethesda, MD 20889
Main: (301) 295-4611
APU Surgery Check-in: Building 10, 3rd Floor

PATIENT RESPONSIBILITIES PRIOR TO SURGERY:

1. **Have a responsible adult (≥18 years) to take you home and stay the night after being discharged.** Your escort must stay in the hospital/facility at all times. If you cannot make these arrangements, contact your surgeon before your surgery date to be rescheduled. Visitors will wait in the family lounge area during your surgery and will be notified by the hospital staff when they can see you during the post-operative care. Note that Taxi cabs and Rideshare Apps (Uber/Lyft) are NOT acceptable and surgery may be cancelled if no responsible adult is available.

2. Complete all ordered labs, EKGs, x-rays, and diagnostic tests prior to your surgery/procedure time (as needed).

3. **Adhere to your medication regiment as outlined by your surgeon or modified by anesthesia staff. Take all regularly scheduled medications with a sip of water the morning of surgery unless otherwise instructed by anesthesia/surgeon.**
☐ DO NOT take aspirin-containing medications, or Ibuprofen/Motrin/Advil/Naproxen/Aleve type medications, including over-the-counter, for ____ days prior to and ____ days after your surgery.
☐ DO NOT take herbal/dietary supplements (e.g. workout supplements, gingko biloba, garlic, ginger, fish oil, omega-3, or vitamin E, etc.), herbal teas, and diet supplements 2 weeks prior to surgery.
☐ Patients who have had heart stents or heart conditions, consult your cardiologist before stopping any medication.

4. If you were not scheduled to be seen for an APU Prescreen appointment, you will be contacted by a perioperative staff member for a telephone consultation within 72 hours prior to your surgery date.

5. If you wish to cancel your procedure, or if you develop a fever, rash, cold, sore throat, or other illness between now and your surgery date, contact your surgeon in their respective clinic. If after hours, please contact the main hospital number to have the surgeon on call paged to speak to you (except MGMCSC).

6. Complete all pre-op preparations as instructed by your surgical clinic. This includes bowel and skin prep, if applicable.

7. If you are a smoker, please talk to your primary care about smoking cessation. Please refrain from smoking 24 hours prior to surgery. Please call 1-800-QUIT-NOW (784-8669) for assistance and refer to our smoking cessation materials.

Patient Name (Last, First, MI): _____
Patient DOD ID Number: _____
Patient Date of Birth: _____

THE BUSINESS DAY PRIOR TO YOUR SURGERY/PROCEDURE: (date) _____ CALL FOR REPORT/ARRIVAL TIME:
Arrival times are determined by the main operating room, not the surgeon. Please do not come any earlier than your scheduled arrival time.

☐ **Fort Belvoir Community Hospital**
(571) 231-4503
2:30 pm – 4:30 pm (1430-1630)

☐ **Kimbrough Ambulatory Care Center**
(301) 677-8020 or (301) 677-8019
1:00 pm – 4:00 pm (1300-1600)

☐ **Malcolm Grow Medical Clinic and Surgery Center**
(240) 612-2004 or (240) 612-1957
2:00 pm – 4:00 pm (1400-1600)

☐ **Walter Reed National Mil Med Center**
(301) 295-2563
1:30 pm – 4:00 pm (1330-1600)

THE EVENING BEFORE YOUR SURGERY/PROCEDURE:
1. Unless otherwise directed, on the night prior to your procedure, **DO NOT EAT ANYTHING AFTER MIDNIGHT OR DURING THE DAY LEADING UP TO YOUR PROCEDURE.** This includes coffee, tea, toast, candy, or gum. Clear liquids (excluding alcohol) may be ingested for up to 2 hours before arrival time.
2. Do not consume any **alcohol** or use **tobacco** products 24 hours prior to your procedure.

THE DAY OF THE SURGERY/PROCEDURE:
1. **Bring with you** to the hospital:
   - Military or Government-issued ID card
   - "Pre-op Check" sticker sheet (if required to perform surgical skin wipes from surgeon)
   - Crutches, walkers, canes, or wheelchairs if required
   - CPAP machine if required
   - Any inhalers, if prescribed. Otherwise, please do not bring home medications.
   - Copy of Advanced Directive, Living Will, 5 Wishes, or Power of attorney (if applicable)
2. If instructed to take any medications by mouth on the morning of your procedure, do so with a small sip of plain water.
3. **For children less than 13 years old only:**
   - No solid food after midnight the evening prior to the procedure.
   - Clear liquids up to two hours prior to arrival time.
   - Breast milk up to four hours prior to arrival time.
   - Infant formula up to six hours prior to arrival time.
   - All non-human milk up to six hours prior to arrival time.
   - You may bring pajamas, a favorite blanket, and/or a favorite toy to comfort them.
4. You may shower and brush your teeth with *sips* of water.
5. Wear comfortable, loose-fitting clothes and preferably a button-down shirt. You may have bulky dressings placed during surgery. Wear comfortable shoes.
6. **DO NOT wear** makeup, nail polish, or contact lenses. Remove all removable metal objects from your body and hair. All piercings, adornments, dentures, hearing aids, contact lenses, and glasses must be removed prior to going to the OR. Do not apply lotion, perfume, cologne, scented deodorant, or powder after showering. Do not shave area of surgery.

AFTER SURGERY:
1. Anesthesia effects may linger. For the first 24 hours after surgery, DO NOT drive, operate hazardous machinery or power tools, drink alcohol, take any medications other than prescribed, or make legal decisions.
2. Remain quietly at home for the day and rest. Arrange for someone to care for your small children for the day. It is recommended that you have someone check on you for the first 24 hours.
3. Take liquids first and slowly progress to a light meal.
4. If you are staying overnight for observation, you will be discharged by 0800 the next morning.

Staff Name _____ Staff Signature _____ Date _____
Patient Name _____ Patient Signature _____ Date _____
(Last, First, MI)