Dear patient,

You have just been admitted to the Clinique du Golfe de Saint-Tropez, a Sainte-Marguerite health care facility. Our medical practitioners, support staff and management team thank you for your confidence.

In accordance with the legislation in effect, this patient information booklet, as its name suggests, brings together the medical and administrative information needed to ensure the quality and safety of the care that you will receive.

You must carefully **read and complete** the various documents (information sheets, questionnaires, authorisations) that make up this booklet. They are indispensable for your admission to our health care facilities. **You can, if needed, fill out these documents with the help of your loved ones.**

Further information will be provided to you by the anaesthetist whom you will meet and by the medical practitioner who will be treating you.

If your state of health or medical condition requires you to be hospitalised, you will also receive our welcome booklet providing further information about your stay.

We hope that this information booklet helps you to feel confident about the quality and safety of the care provided at Sainte-Marguerite facilities.

Dr Bruno Thiré, Chief Executive

****

... CONTENTS ...

I. Required information and authorisations

II. Designations / Administrative and medical authorisations

PLEASE COMPLETE IF YOU ARE…

An adult patient's representative or legal guardian

Please complete this section if the patient does not have the capacity to complete the booklet or understand this information

Contact information for the patient's ☐ representative / ☐ legal guardian:[1]

Surname: .....
First name: .....
Relationship to the patient: .....
Telephone: .....
Mobile phone: .....

Signature of the patient's representative or legal guardian

Holder(s) of parental responsibility for a patient who is a minor

Articles 371-1, 372, 372-2 of the French Civil Code (*Code civil*)
Articles L.1111-5, R.1111-2, R.1112-35 of the French Public Health Code (*Code de la santé publique*)

The signatures of both parents are compulsory when the parents share parental responsibility (e.g. a child born of married parents or born of unmarried parents who officially recognised the child in his or her first year of life). **If one of the parents is far away**, it is possible to send us the information in this booklet with his or her signature **by fax, post or email** preadmission@clinique-st-jean.fr

This information booklet must be completed and signed by the holders of parental responsibility and presented before the pre-anaesthesia consultation.
If not, the procedure may have to be postponed.

The signatories of this booklet certify and attest that the exercise of their parental responsibility has not been limited by a court decision. Otherwise, a copy of the decision must be sent to your doctor as soon as possible.
The holders of parental responsibility:

- undertake to share information with each other about the hospitalisation of their child, the care and treatment provided to him or her and any changes in his or her state of health;
- each attest that the contents of this booklet have been fully explained to him or her and that he or she has read, completed and understood the booklet;
- each attest to the accuracy of all the information about him or her in this booklet.

Identification of the holder(s) of parental responsibility

☐ **The child's father**	☐ **The child's mother**	☐ **Legal guardian**[1]
Surname:	Surname:	Surname: .....
First name:	First name:	First name: .....
Date of birth:	Date of birth:	Date of birth: .....
Telephone:	Telephone:	Telephone: .....
Mobile phone:	Mobile phone:	Mobile phone: .....
Address:	Address:	Address: .....
Signature:	**Signature:**	**Signature:**

Admission and discharge of a patient who is a minor

If the holder(s) of parental responsibility cannot be present on the days when their child is admitted to, and discharged from, the health care facility, the person(s) designated hereafter is/are authorised to accompany the child[2].

Surname, first name:	Surname, first name: .....
Relationship to the child:	Relationship to the child: .....
Telephone:	Telephone: .....
Mobile phone:	Mobile phone: .....

SAFETY: A patient who is a minor may not leave the facility unless accompanied by an adult.

[1]: A copy of the legal guardian's identity document and a copy of the guardianship order will be kept in the patient's file.
[2]: The accompanying adult must present his or her identity document to a registered nurse on the ward. A copy of it will be kept in the patient's file.

Authorisation to operate on a patient who is a minor or an adult patient under guardianship

I, the undersigned,

father,[1] *(surname and first name)* .....

mother,[1] *(surname and first name)* .....

legal guardian,[1] *(surname and first name)* .....

of the child or the adult under guardianship (patient's surname at birth and first name) ..... ,

born on ..... in .....

authorise the anaesthetist to anaesthetise this child (or this adult under guardianship), and Dr (doctor's surname and first name) .....

to operate and provide all necessary care and treatment for his or her state of health.

Signature of the father and mother or legal guardian [1] of the child or of the adult under guardianship

(1). **The signatures of both parents are mandatory if parental responsibility is shared** (e.g. a child born of married parents or born of unmarried parents who both recognised their child in his or her first year of life).
Please cross out those that do not apply

1. Information provided by the medical practitioner about the proposed surgical procedure

ACKNOWLEDGEMENT OF UNDERSTANDING THE INFORMATION

INFORMED CONSENT FOR SURGERY

As requested by Dr....., and in order to comply with **legal obligations**, I, the undersigned, Mr/Mrs/Ms ....., born on ..... / ..... / ....., declare that I have been **informed** in detail by him/her about the serious risks, including life-threatening risks, inherent in any surgical procedure and, in particular, infectious risks that might arise from the procedure that I shall undergo.

I have been informed of the existence of a specific percentage of serious **complications**, possible **after-effects** and **risks**, including life-threatening risks, relating not only to the medical condition and any pathological associations that I may have, but also to unexpected individual reactions and possible medical accidents.

I have been able to ask the surgeon all my questions about the surgery. I have noted that, in addition to the previously mentioned risks, there is unpredictability with regard to duration, specific aspects of anatomic areas, the healing process, and rare or even unknown risks.

I have been informed by the surgeon of the expected **benefits** from this operation, the risk of failure or a disappointing outcome, therapeutic **alternatives**, as well as the possibility of a later need to operate again. The **explanations** provided were done so in sufficiently clear terms to enable me to make my decision and **ask** the surgeon to perform this operation.

I have also been informed that, during the operation, the surgeon may be confronted with a discovery or an unforeseen event necessitating additional or different procedures from those initially planned, and I hereby authorise the surgeon, in such conditions, to perform any procedure that he/she deems necessary and, to this end, to be assisted by another medical practitioner if required.

I expressly undertake to go to the planned consultations, undergo all treatments and follow all precautions and recommendations prescribed to me before and after the surgery.

I trust Dr ..... to use all means at his/her disposal to reach the hoped-for outcome.

This document does not constitute a liability release, but rather an acknowledgement that I have understood the information provided.

Done in..... on.....

Name and signature of the medical practitioner who is responsible for the patient

Surname at birth and signature of the patient or the patient's representative (preceded by the words "read and approved")

2. Information provided by the anaesthetist about the proposed type of anaesthesia

INFORMED CONSENT FOR ANAESTHESIA

I declare that, during my anaesthesia consultation with Dr ....., I have been fully informed of the benefits and risks of anaesthesia. I have been able to ask all the questions that I deemed useful and I have understood the answers that were provided to me.
I accept all useful modifications to methods during the procedure.

This document does not release the anaesthetist from his or her liability with respect to me.

Done in..... on.....

Name and signature of the anaesthetist

Surname at birth and signature of the patient or the patient's representative (preceded by the words "read and approved")

3. Evaluation of risks related to prions (unconventional transmissible agents)

You are about to enter the hospital to undergo a diagnostic or therapeutic procedure. In order to detect and prevent a potential risk of transmitting Creutzfeldt-Jakob disease and other transmissible spongiform encephalopathies (TSEs), and in compliance with Instruction DGS/RI3 no. 449 of 1 December 2011 and Circular DGS/SD5C/DHOS no. 435 of 23 September 2005, we ask you to answer the following questions, if necessary with the help of your doctor.

1. **Have you ever been treated for a growth disorder through the injection of human growth hormone?** Yes ☐ No ☐
2. **Have you ever undergone a procedure involving a human dura mater graft?** Yes ☐ No ☐
3. **Has any member or your genetic family had a transmissible spongiform encephalopathy linked to a mutation in the gene encoding PrP?** Yes ☐ No ☐
4. **Have you been identified as having received labile blood products from a donor subsequently recognised as having Creutzfeldt-Jakob disease?** **Yes ☐*** No☐

***If the answer is yes, any invasive procedure will be deemed at risk with regard to prions.**

I, the undersigned, attest to the accuracy of the information provided above.

Date, surname at birth and signature of the patient or the patient's representative

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P a r t i e r é s e r v é e a u p r a t i c i e n

Le patient présente-t-il après élimination des autres causes possibles, un signe neurologique d'apparition récente et d'évolution progressive sans rémission, d'au moins un signe clinique neurologique *(Myoclonies, troubles visuels ou cérébelleux ou pyramidaux ou extrapyramidaux, ataxie, chorée, dystonie, symptômes sensitifs douloureux persistants, épilepsie, mutisme akinétique)* associé à des troubles intellectuels *(démence, ralentissement psychomoteur)* ou psychiatriques (*dépression, anxiété, apathie, comportement de retrait, délire)*.

Si le patient présente une suspicion d'EST, il faut revoir l'indication de l'acte et demander au préalable un examen neuropathologique et si la conclusion est positive en faveur d'une suspicion, il faut appliquer les modalités de traitement recommandées dans l'Instruction N°449.

Selon le processus déclaratif du patient et l'examen clinique, veuillez cocher la case qui correspond au niveau où se répertorie le patient :

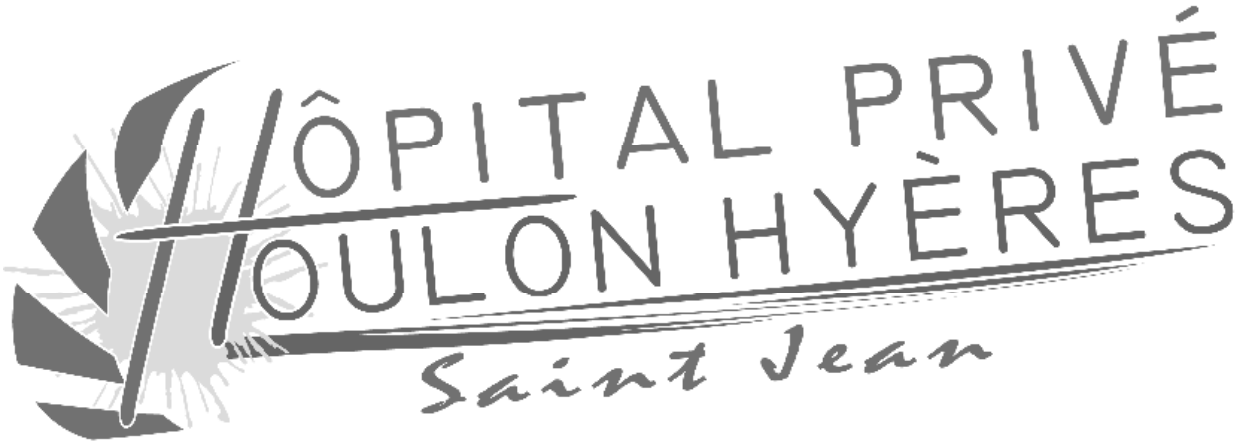
PNSNA ☐

Patients Ni Suspects Ni Atteints
regroupant les patients sans caractéristique particulière et ceux ayant répondu positivement aux précédentes questions sans confirmation de la suspicion d'EST

PSA ☐

Patients Suspects ou Atteints
Si confirmation de la suspicion par un examen neuropathologique

Nom et signature du praticien responsable du patient



Anaesthesia file

Surname at birth:
Married name:
First name:
Date of birth:
Age:

Patient label

General information about anaesthesia

Anaesthesia and Intensive care Department
Hôpital Privé Toulon Hyères – Saint Jean
Avenue Georges Bizet
Téléphone : 04.98.00.14.70 - Fax : 04.94.00.14.7
Email : scpcsj83@wanadoo.fr

The aim of this anaesthesia file is to provide you with information about anaesthesia, including its advantages and risks. We ask you to read it carefully so that you can give your informed consent to the anaesthetic procedure that the anaesthetist will plan for you. You can also ask the anaesthetist questions about your anaesthesia. Regarding the medical procedure requiring anaesthesia, the specialist who will carry out that procedure will be able to answer your questions.

What is anaesthesia?

The term "anaesthesia" covers the techniques used to eliminate or decrease pain during surgery, obstetrics or medical examinations (e.g. endoscopy, X-rays, etc.).
There are two main types of anaesthesia: general anaesthesia and local anaesthesia.

General anaesthesia is a state similar to sleep and is induced through the intravenous injection of medication and/or breathing in anaesthetic gases with the appropriate equipment.

Local anaesthesia uses various techniques to numb only the part of the body undergoing surgery. To do so, a local anaesthetic is injected into this area to numb the nerves. A general anaesthetic may be combined with local anaesthetic or become necessary if the local anaesthetic proves insufficient.

Spinal anaesthesia and epidural anaesthesia are two specific types of local anaesthesia whereby the anaesthetic is injected close to the spinal cord and the nerves that branch out from it.

Any general or local anaesthesia performed for a non-emergency procedure requires a consultation several days in advance and a pre-anaesthesia visit the day before or a few hours before the anaesthesia, depending on the hospitalisation conditions.

During the consultation and the visit, you are encouraged to ask any questions that you consider useful. A decision on the type of anaesthesia to be used will be made on the basis of the procedure, your state of health and the results of any additional tests that may or may not be ordered. The anaesthetist who will perform your anaesthetic procedure is responsible for making the final decision.

How will I be monitored during anaesthesia and upon awakening ?

Anaesthesia, regardless of which type, takes place in a room equipped with appropriate equipment that is adapted to your case and checked before each use. Anything that is in contact with your body is either disposable or is disinfected or sterilised. After the procedure, you will be taken to a post-anaesthesia care unit (recovery room), where you will be continuously watched. Then you will go to your hospital room or leave the hospital.
During anaesthesia and the time spent in the post-anaesthesia care unit, you will be taken care of by qualified nursing staff under the responsibility of an anaesthetist.

What are the risks of anaesthesia?

Any medical procedure, even when carried out skilfully and in accordance with established scientific knowledge, carries a risk.
Modern methods of monitoring anaesthesia and awakening allow us to detect any anomalies and to treat them quickly. For this reason, it is important to tell the anaesthetist and the nursing staff monitoring you if you feel any pain or discomfort during or after anaesthesia.

What are the disadvantages and risks of a general anaesthetic?

Nausea and vomiting upon awakening have become less common thanks to new techniques and new medicines.
Incidents arising from vomit going into the lungs are now very rare, especially if the fasting guidelines are properly followed.

The insertion of a tube into the trachea (intubation) or into the throat (laryngeal mask) to ensure respiration during anaesthesia may cause a sore throat or temporary hoarseness.

Damage to teeth may also occur. For this reason, it is important to notify us if you wear any kind of denture or if your teeth are fragile in any way.

A painful redness may occur around the vein where the medication has been injected. It will disappear within a few days.

Prolonged immobility on the operating table may cause compression, particularly of some nerves, leading to numbness or, in rare cases, paralysis of an arm or a leg. In the majority of cases, everything returns to normal within a few days or weeks.

Temporary memory problems or a lowered ability to concentrate may occur in the hours following the anaesthetic.

During the 24 hours after anaesthesia, you are strongly advised not to drink alcohol, drive a vehicle, use potentially hazardous equipment or make any important decision because **you might have decreased alertness without realising it.**

Unforeseen life-threatening complications such as a serious allergic reaction, cardiac arrest or asphyxia are extremely rare. We mention these examples, but hundreds of thousands of anaesthetic procedures of this type are performed every year without incident.

<u>What are the disadvantages and risks of a local anaesthetic?</u>

After spinal anaesthesia or epidural anaesthesia, headaches may occur, requiring several days of rest and/or a specific local treatment.

Temporary paralysis of the bladder may necessitate the fitting of a urinary catheter.

Pain around the puncture site on the back may also occur. If a problem arises, it may be necessary to use a second puncture site during anaesthesia.

The administration of morphine or one of its derivatives may cause temporary itching.

Very occasionally, a temporary decrease in visual or auditory acuity occurs.

Depending on the combination of medications used, temporary memory problems or a lowered ability to concentrate may occur in the hours following the anaesthetic.

More serious complications such as convulsions, cardiac arrest, permanent paralysis or varying degrees of loss of feeling are extremely rare. We mention these examples, but hundreds of thousands of anaesthetic procedures of this type are performed every year without incident.

During local anaesthesia for eye surgery, damage to the eyeball is extremely rare.

TO BE COMPLETED BY THE PATIENT

Anaesthesia questionnaire

Surname at birth : ..... First name : .....

Married name : ..... Date of birth : .....

Address : .....

..... Telephone : .....

Weight : ..... Height: ..... Occupation : .....

Recent change in weight : ☐ no ☐ yes If yes :

Weight gain: .....kg since : .....

Weight loss: .....kg since : .....

Procedure : ..... Surgeon : .....

..... Gynaecologist : .....

Date of procedure : ..... General practitioner : .....

Please <u>list all</u> of YOUR current medications : ☐ I am not taking any medication.

Medication	Dose	Morning	Noon	Evening	Medication	Dose	Morning	Noon	Evening
-					-				
-					-				
-					-				
-					-				
-					-				

1) Within the last 12 months

Have you been hospitalised in the intensive care unit ? Yes ☐ No ☐

Have you been hospitalised in another country ? Yes ☐ No ☐

2) Are you a known carrier of multidrug-resistant bacteria or have you been in contact with a person who is a carrier of such bacteria ? Yes ☐ No ☐

3) Are you a known carrier of emerging highly drug-resistant bacteria or have you been in contact with a person who is a carrier of such bacteria ? Yes ☐ No ☐

4) Have you taken several courses of strong antibiotics within the last six months ? Yes ☐ No ☐

5) Have you ever undergone surgery, been anaesthetised or hospitalised ? Yes ☐ No ☐

If yes, please indicate when and for what reason(s). .....

.....

.....

.....

.....

6) Have you ever been under general anaesthesia ? Yes ☐ No ☐

7) Have you ever been under local anaesthesia, dental anaesthesia or other types of anaesthesia ? Yes ☐ No ☐

8) Have you ever had any complications during anaesthesia in the past ? Yes ☐ No ☐

If yes, please describe. .....

.....

.....

9) Have there ever been any anaesthesia-related problems in your family ? Yes ☐ No ☐

If yes, what kind of problems ? .....

.....

TO BE COMPLETED BY THE PATIENT

Surname at birth:
Married name:
First name:
Date of birth:
Age:

Patient label

10) Do you have any of the following problems?

Cardiovascular problems

Name of your cardiologist : .....

Date of your most recent consultation : .....

- High blood pressure (hypertension) Yes☐ No☐
- Heart murmur Yes☐ No ☐
- Angina :
  - Pain during physical effort Yes ☐ No ☐
  - Pain at rest Yes ☐ No ☐
- Have you ever had :
  - A heart attack ? Yes ☐ No ☐
  - Palpitations ? Yes ☐ No ☐
  - Heart failure ? Yes ☐ No ☐
- Do you have arterial problems ?
  - Arteritis Yes ☐ No ☐
  - Carotid artery problems Yes ☐ No ☐
  - Peripheral arterial disease Yes ☐ No ☐
- Do you have vein problems ?
  - Varicose veins Yes ☐ No ☐
  - Heaviness in the legs Yes ☐ No ☐
  - Previous phlebitis Yes ☐ No ☐
  - Previous pulmonary embolism Yes ☐ No ☐
  - Superficial thrombophlebitis Yes ☐ No ☐
- Have you had any of these medical exams ?
  - Stress test Yes ☐ No ☐
  - Coronary angiography Yes ☐ No ☐
  - Other tests ..... Yes ☐ No ☐
- Do you have stents ? Yes ☐ No ☐
- Do you have a pacemaker ? Yes ☐ No ☐

Lung problems

- Do you smoke ? Yes ☐ No ☐
  - If yes, how many cigarettes per day? .....
  - If yes, since when ? .....
- Do you take any illegal drugs ? Yes ☐ No ☐
- Do you have asthma ? Yes ☐ No ☐
  - If yes, frequent asthma attacks: Yes ☐ No ☐
    - Childhood asthma Yes ☐ No ☐
    - Treatment Yes ☐ No ☐
- Do you have bronchial problems ?
  - Chronic bronchitis Yes ☐ No ☐
  - Frequent bronchitis Yes ☐ No ☐
  - Emphysema Yes ☐ No ☐
- Morning cough ? Yes ☐ No ☐

Digestive problems

- Have you ever had:
  - An endoscopy ? Yes ☐ No ☐
  - A colonoscopy ? Yes ☐ No ☐
- Do you have gastric problems ?
  - Gastric ulcer Yes ☐ No ☐
  - Hiatus hernia Yes ☐ No ☐
  - Heartburn Yes ☐ No ☐
  - Intolerance to anti-inflammatory drugs Yes ☐ No ☐
- What is your alcohol consumption ?
  - Wine: Yes ☐ No ☐
  - Other kinds of alcohol: ..... Yes ☐ No ☐
- Do you have bowel problems ?
  - Constipation Yes ☐ No ☐
  - Diarrhoea Yes ☐ No ☐
  - Blood in faeces Yes ☐ No ☐
- Do you take laxatives ? Yes ☐ No ☐
- Do you have liver problems ?
  - Hepatitis A Yes ☐ No ☐
  - Hepatitis B Yes ☐ No ☐
  - Hepatitis C Yes ☐ No ☐
  - Other liver problems : Yes ☐ No ☐
- Do you have any other problems or conditions ?

.....

.....

Nephrology/Urology

- Kidney stones Yes ☐ No ☐
- Urinary infections Yes ☐ No ☐
- Chronic kidney disease Yes ☐ No ☐

TO BE COMPLETED BY THE PATIENT

Surname at birth:
Married name:
First name:
Date of birth:
Age:

Patient label

Men:

Do you have prostate problems ? Yes ☐ No ☐

Gynaecology

Number of pregnancies : .....

Number of births : .....

Date of your last menstruation : .....

Are you pregnant ? Yes ☐ No ☐

Have you ever had an epidural during labour ?

Yes ☐ No ☐

Neurology

Migraines	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐
Seizures during childhood	Yes ☐ No ☐
Panic attacks	Yes ☐ No ☐
Tetany	Yes ☐ No ☐
Hemiplegia	Yes ☐ No ☐
Speech disorders	Yes ☐ No ☐
Stroke	Yes ☐ No ☐

Allergies

- Do you have any allergies ?

Yes ☐ No ☐

If yes, what allergies?

- **Rubber or latex** Yes ☐ No ☐
- Hives (urticaria) Yes ☐ No ☐
- Hay fever Yes ☐ No ☐
- Eczema Yes ☐ No ☐
- Asthma Yes ☐ No ☐
- Angioedema Yes ☐ No ☐
- Food allergies: Yes ☐ No ☐

  Banana, kiwi, avocado, chestnuts, melon

  Other foods : .....

- Antibiotics Yes ☐ No ☐
- Aspirin Yes ☐ No ☐
- Other medication Yes ☐ No ☐

  If yes, which medication ? : .....

- During radiological examinations (X-rays)

Yes ☐ No ☐

Other medical conditions

- Do you have diabetes ? Yes ☐ No ☐

  If yes, what is your treatment ?

  Pills ☐

  Insulin ☐

  Diet ☐

Since when ? .....

- Do you have any psychological problems ?

  Depression Yes ☐ No ☐

  Anxiety Yes ☐ No ☐

  Insomnia Yes ☐ No ☐

- Do you have glaucoma? Yes ☐ No ☐
- Do you wear any of the following?

  Contact lenses Yes ☐ No ☐

  Hearing aid Yes ☐ No ☐

  Other prostheses Yes ☐ No ☐

- Do you have sleep apnoea? Yes ☐ No ☐

  If yes, do you use a device while you sleep

Yes ☐ No ☐

Other medical tests carried out: .....

.....

.....

TO BE COMPLETED BY THE PATIENT

11) Have you ever received a blood transfusion ? Yes ☐ No ☐

If yes, please provide the date(s) : .....

.....

Has your blood been tested since then ? Yes ☐ No ☐

Are you opposed to receiving a blood transfusion in an emergency ? Yes ☐ No ☐

If yes, please explain why. .....

12) Viral status :

Have you had blood tests to check for: Hepatitis B? Yes ☐ No ☐

Hepatitis C? Yes ☐ No ☐

HIV?* Yes ☐ No ☐

Unless you are opposed to it, **blood testing for** HIV,* hepatitis B and hepatitis C **may be done during your hospitalisation in the event of an accident involving exposure to a staff member's blood**.

Do you authorise such tests ?

If not, please provide a reason : .....

Have you taken aspirin or a derivative of aspirin within the last eight days?

Is there anything that we should know that has not been covered by this questionnaire?

.....

.....

.....

I, the undersigned, attest to the accuracy of the information provided above.

Surname at birth and signature of the patient or the patient's representative

* Human immunodeficiency virus, the virus that causes AIDS.

HÔPITAL PRIVÉ TOULON HYÈRES
SAINT JEAN
ETABLISSEMENTS SAINTE MARGUERITE

Date : …… / …… / ……
Chirurgien : ……
MAR : ……
I.A.D.E : ……

Nom de naissance :
Nom d'usage :
Prénom :
Date de naissance :
Age :

Etiquette patient

SUIVI ANESTHESIQUE PER INTERVENTIONNEL

Type d'intervention : ……

Heure induction : ……h…… **Heure incision** : ……h……

Présence permanente de l'Anesthésiste ☐

Type d'anesthésie :

☐ AG ① ☐ MF ☐ ML ☐ INT | ☐ AL + Sédation ① ☐ Sédation ① | ☐ ALR ⑤ ☐ RA ③ ☐ APD ② ☐ Bloc Nerv ④ | ☐ KT PeriN ⑤ ☐ APB ⑤ ☐ Topique + Sédation ①

Ventilation : ☐ VS ☐ VC ☐ VPC ☐ N2O ☐ 02
☐ Circuit ouvert ☐ Circuit fermé ☐ Air
☐ Halogéné ……

Contrôle des voies aériennes : ☐ Non ☐ Oui Si oui : ☐ IOT ☐ INT sonde n°: …… ☐ AD ……
☐ Masque laryngé n°: ……
☐ Autre : ……

Paramètres ventilation : ……
……

Ventilation au masque : ☐ Facile ☐ Difficile

Intubation : ☐ Facile ☐ Difficile ☐ Cormack :
……

Position opératoire : ☐ DD ☐ DLD ☐ DLG ☐ DV
☐ Autre : ……

Monitorage : ☐ SFAR* ☐ ECG ☐ PNI ☐ SPO2 ☐ Autre : ……
SFAR = ECG, PNI, SPO2, FIO2, ETCO2*

☐ **VVP** …… ☐ D ☐ G ☐ **VVC** ……

Bloc nerveux périphérique	Nerf / Localisation				
Echo : ……	……	……	……	……	……
Neuro Stimulateur : ……	……	……	……	……	……
IMS : ……	……	……	……	……	……
Aiguille : ……	……	……	……	……	……
Produit : ……	……	……	……	……	……
Quantité : ……	……	……	……	……	……

Couverture chauffante : ☐ Oui ☐ Non **Protection yeux** : ☐ Oui ☐ Non **Réchauffeur de solutés** : ☐ Oui ☐ Non

☐ **Sonde gastrique : N°** ……

Sonde thermique : ☐ Oui ☐ Non

☐ **Sonde Vésicale : N°** ……

		H :						H :						H :						H :					
TA	220																								
Pouls																									
SaO2	200																								
EtCO2																									
T°	180																								
TOF																									
Garrot	160																								
Antibioprophylaxie	140																								
Molécule :																									
Dose :	120																								
Heure d'injection :																									
	100																								
	80																								
	60																								
	40																								
VV1																									
VV2																									
Diurèse																									
Pertes sanguines																									

Transfusion : ☐ Non ☐ Oui si oui Cf. dossier transfusionnel

Cell Saver : ☐ Non ☐ Oui si oui Cf. dossier transfusionnel

Evènements indésirables : ☐ Non ☐ Oui, si oui précisez : ……..……

……..……

Nom de naissance :
Nom d'usage :
Prénom :
Date de naissance :
Age :

Etiquette patient

HÔPITAL PRIVÉ TOULON HYÈRES
SAINT JEAN
ETABLISSEMENTS SAINTE MARGUERITE

SURVEILLANCE POST-INTERVENTIONNELLE

Nom de naissance :
Nom d'usage :
Prénom :
Date de naissance :
Age :
Etiquette patient

Allergies :

Date : / / 20
Nom Anesthésiste :
Type d'anesthésie :
☐ AG ① : ☐ MF ☐ ML ☐ INT
☐ AL + Sédation ① ☐ Sédation ①
☐ ALR ⑤ : ☐ RA ③ ☐ APD ② ☐ Bloc Nerv ④
☐ KT PeriN ⑤
☐ APB ⑤
☐ Topique + Sédation ①

	2	1	0
Motricité spontanée :	Bouge 4 membres	Bouge 2 membres	Immobile
Respiration :	Peut respirer profondément et tousser	Dyspnée, respiration superficielle, limitée	Apnée
Pression artérielle :	+/- 20mm Hg	+/- 50 mm Hg	Plus de 50 mm Hg
Etat de conscience :	Parfaitement réveillé	Se réveille à la demande	Ne répond pas aux ordres simples
Coloration :	Normale	Pâle, grisâtre marbré ictérique	Cyanosé
Saturation :	SpO2 > 92% à l'air ambiant	Nécessité d'un apport en O2 pour maintenir la SaO2 > 92%	SpO2 < 90% malgré l'apport d'O2

Identification IDE / AS															
Nom				**Nom**				**Nom**							
Initiales				**Initiales**				**Initiales**							
Visa				**Visa**				**Visa**							

CRITERES D'ALDRETE	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :	H :
Motricité spontanée															
Respiration															
Pression artérielle TA habituelle :															
Etat de conscience															
Coloration															
Saturation															
TOTAL															
Pouls															
Tension Artérielle															
02															
Fréquence respi.															
Température															
Pansement															
Drain 1															
Drain 2															
Drain 3															
Cell Saver															

Sonde nasogastrique															
Sonde à demeure															
Irrigation vésicale posée															
Irrigation vésicale vidée															
Diurèse															
Aspect des urines															
Mobilité	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Sensibilité	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non	☐ Oui ☐ Non
Nausées Vomissements Post Op															
Hemocue / Saignements															
Hémoglucotest															
Voie Veineuse Périphérique 1															
Voie Veineuse Périphérique 2															
Voie Veineuse Centrale : ☐ Oui ☐ Non			KT Artériel : ☐ Oui ☐ Non			KT Périnerveux : ☐ Oui ☐ Non				Dispositif chauffant : ☐ Oui ☐ Non					
Perfusions / Injections															
Transfusions															
Examens (labo, ECG, etc..)															
Vessie de glace		Observations diverses :													
Patient porteur du bracelet d'identification : ☐ Oui ☐ Non, si non → repose du bracelet ☐															
EVA / EN / EVS															
Initiales de l'IDE															

Réservé Médecin

Incidents péri anesthésiques : ☐ Non ☐ Oui, précisez :

Score d'Aldrete : **EVA / EN / EVS de sortie** : **Heure de sortie** :	**Nom du Médecin responsable de la sortie**	**Signature du Médecin responsable de la sortie**	Nom de naissance : Nom d'usage : Prénom : Date de naissance : Age : *Etiquette patient*

II. Designations / Administrative and medical authorisations

Law no. 2202/303 of 4 March 2002 on **patients' rights and the quality of the health system)**

I, THE UNDERSIGNED,.....

Authorise :

- General and/or local anaesthesia
- The surgical procedure(s)
- The appropriate care and treatments
- If necessary, treatments prescribed by the doctor on duty

People to contact in an emergency

I authorise the facility to contact, **in case of administrative necessity**, the person(s) designated hereafter:

Surname, first name:	Surname, first name: .....
Relationship to the child:	Relationship to the child: .....
Telephone:	Telephone: .....
Mobile phone:	Mobile phone: .....

Request for confidentiality

☐ **I request that my anonymity be protected and my stay at your facility be kept confidential.**

Designating a trusted person

In accordance with Law no. 2002-303 of 4 March 2002 on patients' rights and the quality of the health system, specifically Article L1111-6, the patient can designate **a trusted person** who will be consulted should the patient become unable to express his or her desires and who will receive the required information for this purpose.

☐ **I wish to designate a trusted person :**

Surname, first name: ..... Date and place of birth: .....

Address: .....

Telephone number: ..... Mobile phone number: .....

- This legally competent person is: ☐ A friend ☐ A relative ☐ My general practitioner
- I would like this person to support me through the whole process and to be present during my medical appointments in order to help me with my decision-making: Yes ☐ No ☐

I have been informed that this designation covers the whole duration of my hospitalisation.
I can cancel this designation at any time. In such a case, I undertake to inform the hospital in writing.

To be signed by the trusted person:

I, the undersigned, ...
declare that I have been informed of my designation as the trusted person.
Done in .....
On .....

The trusted person's signature

☐ **I do not wish to designate a trusted person:** I declare that I have been informed of the possibility provided to me to designate a trusted person for the duration of my hospital stay. I do not, however, wish to designate a trusted person. I am aware that I can still designate someone at any time and, in such a case, I undertake to inform the hospital of my choice in writing.

Signature of the patient
or the patient's representative

The management, support staff and medical team
thank you for taking the time to read all the information in this booklet,
which is indispensable for treating you in our facility,
in compliance with the recommendations of
the French National Authority for Health (HAS).

V.01