Obstetric Surgery Pre-Operative Evaluation Form

Patient Name

Hospital Number

Date of Birth

Age

Date of Admission

Expected Date of Surgery

Diagnosis

Gravida

Parity

Gestational Age (weeks)

Indication for Surgery

Relevant Medical / Surgical History

Allergies

Blood Group

Hemoglobin (g/dL)

BLOOD Ready?

Vital Signs

Blood Pressure

Pulse Rate

Temperature

Other Relevant Examination Findings

Investigations Performed

Medications/Pre-operative Orders

Anesthetist Evaluation Findings

Consent Obtained

Form completed by

Date