Banff Sport Medicine

BANFF SPORT MEDICINE
Orthopaedic Surgeons

P: 403 760 2897 F: 403 760 8234
banffsportmed.ca

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Welcome to Banff Sport Medicine!

The following forms are required to assess your injury with the Surgeon at your upcoming appointment**.**

Please fully complete all forms PRIOR to your appointment to avoid delays. (*If you are unable to print your forms or have questions, please arrive 30 minutes prior to your appointment to allow time to complete your forms before seeing the surgeon.)*

Registration Forms *(not required if completed within the last year)*

- Patient Registration: demographic information
- Informed Consent: allows patient information to be accessed for research purposes
- Initial Consult Patient History: information related to your injury

Surgery Forms

These forms are required by Banff Mineral Springs Hospital if you are consented for surgery

- Covenant Health, Banff Mineral Springs Hospital: Pre-Operative Patient Questionnaire
- Covenant Health: Consent to Disclose Health Information

***Note**: Before surgery is booked approval must be obtained from the Anaesthesia Department at Banff Mineral Springs Hospital (MSH). MSH will review your medical history to determine if you are a low risk candidate. MSH is a rural hospital and does not have tertiary medical services (ICU, blood bank, etc.) and for the safety of our patients we can only operate on patients who are deemed low risk. Please ensure you provide complete details on these forms as missing information may delay the process. Please contact your family physician if you are unsure of any details, such as dates, facilities or names of specialists.*

Thank you from all of us at Banff Sport Medicine!

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Banff Sport Medicine

Patient Registration

Health Care	Number	Province	Expiry Date (if applicable)	**Today's Date**	
Name	***As it appears on your Health Care Card***				
	Full Name - *if **different** than name on Health Care Card*				
Date of Birth	Day / Month / Year			**Age**	**Sex**
Address	Street/Mailing				
	City/Town	Province	Postal Code		

Email	Primary Email	☐ Personal ☐ Work ☐ Other	Secondary Email	☐ Personal ☐ Work ☐ Other
Contact Number	Primary Phone Number	☐ Cell ☐ Home ☐ Work ☐ Other	Secondary Phone number	☐ Cell ☐ Home ☐ Work ☐ Other
Occupation	Job Title	Employer	Phone Number	

Family Doctor	Name	Clinic Name/Location	Phone Number
Emergency Contact	Name	Relationship	Phone Number

Is this a work-related injury?	☐ **NO,** *if no skip section.* ☐ **YES,** *if yes please answer the following questions.*

Date of Injury:	Location:
Employer at time of injury:	
Nature of injury:	
Social Insurance Number:	WCB Claim Number:

Banff Sport Medicine Uninsured Services Policy: Fees for uninsured services (not covered under provincial health care plans) will be at the discretion of the physician. This includes but is not limited to forms required by third parties and government agencies.

Registration Form - June 2022

Banff Sport Medicine - Orthopaedic Surgeons
P: 403 760 2897 F: 403 760 8234

Banff Sport Medicine - Sport Medicine Physicians
P: 403 678 1271 F: 403 621 1932

www.banffsportmed.ca

Banff Sport Medicine

INFORMED CONSENT TO ALLOW PATIENT MEDICAL INFORMATION TO BE ACCESSED IN DATABASE FOR RESEARCH PURPOSES

Banff Sport Medicine is actively involved in research to achieve excellence in the clinical care and surgical reconstruction of sport trauma, in order to provide the best-possible outcomes for our patients. To do this research, the physicians at Banff Sport Medicine compile patient files in a computer database. Information placed onto this system includes details such as your injury type, your rehabilitation program, your sporting activities, age, gender and name. Once compiled patient names are removed and the information is analyzed to assess things such as how often a specific injury occurred, the sports involved and how injuries were rehabilitated.

Your name is needed to identify your file and to identify cases with more than one injury. Should you decide to allow us to use your medical file in this way, your medical history will be kept in strictest confidence. Your name will not appear in any research report, nor will it be made available to persons other than those involved in your health care, their staff and their research associates. This information may also be used for the purposes of contacting you in the future regarding participation in research. There are no perceived risks or benefits associated with your participation. Should you refuse to allow us to use your medical file or if you withdraw your consent, your care will not be compromised in any way.

Your signature on this form indicates that you authorize the custodian of your health records (your physician at the Banff Sport Medicine) to disclose your personal health information for research purposes. You enter this program willingly and may withdraw your consent at anytime without prejudice to future health care. You have understood to your satisfaction why you have been asked to disclose this information and are aware of the risks or benefits of consenting or refusing to consent.

CONSENT

I have read the above information and understand that the purpose of allowing my file data to be used is for research. I understand that I may withdraw my consent at any time without prejudice to further health care. I allow my name and personal health information to be placed on the computer database for the purpose of research or for contacting me for a research study.

☐ **I agree to have my patient information on the Banff Sport Medicine Database used for research purposes or to be contacted by the Banff Sport Medicine Foundation.**

☐ **I do not agree to have my patient information on the Banff Sport Medicine Database to be used for research purposes or to be contacted by the Banff Sport Medicine Foundation.**

Patient Signature_____

Patient Printed Name: _____

Date: _____

If you have any questions regarding the database or its use, please contact your physician at the Banff Sport Medicine at 403.760.2897. This information is collected under the authority of Health Information Act. The above information is collected for clinical and research purposes only.

Banff Sport Medicine

Initial Consult
PATIENT HISTORY

PATIENT NAME: _____Height_____Weight_____Age_____ Date_____

Symptoms / Injury Description

What are you being seen for today? ☐ Right ☐ Left ☐Both Body part _____

Did your problem come on gradually or as a result of an injury? ☐ Gradually Date of onset: _____

☐ Injury Date of injury: _____

Describe what happened: _____

_____

The main problem is? ☐ Pain ☐ Instability ☐ Stiffness ☐ Weakness ☐ Other_____

Rate your injury during the last month (CIRCLE): (no problem) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Does your injury wake you up at night? ☐ Yes ☐ No

What, if anything, makes your injury worse? _____

What, if anything, makes your injury better? _____

Sports / Recreation

List your regular sports/recreation activities:

1. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other_____
2. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other_____

Previous Surgery / Treatments / Tests

Have you had a similar injury or a surgery in the past?:

RIGHT: Injuries? ☐ Yes ☐ No	**LEFT: Injuries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?
RIGHT: Surgeries? ☐ Yes ☐ No	**LEFT: Surgeries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?

What treatment(s) have you had for your injury? ☐ Nothing ☐ Physiotherapy ☐ Medication ☐ Injections

☐ Sling ☐ Surgery ☐ Other: _____

What tests have you had done for your injury? ☐ X-ray ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Bone Scan

Covenant Health
Banff Mineral Springs

PRE-OPERATIVE PATIENT QUESTIONNAIRE

Office Use Only

MSH# IF APPLICABLE_____

All information gathered will be kept confidential.

LEGAL NAME:_____ E-MAIL ADDRESS:_____

AGE: _____ WEIGHT:_____ lb/kg *(CIRCLE ONE)* HEIGHT: _____ ft/cm *(CIRCLE ONE)*

BMI: _____ (CALCULATED BY OFFICE)

FAMILY DR/CLINIC/LOCATION:_____ FAMILY DR PHONE# _____

THIS SECTION IS FOR OFFICE USE ONLY

Surgeon: Date Seen: **OR Date:**

Procedure:

	CBC	Gluc	Bun/Creat	Lytes	EKG	LFT	TSH	HgAIC
Required								
Ordered								
Received								

Orders:

Comments:

Anaesthetic Review Date: OK to Book-NO PAC ☐ Date:

OK to Book: YES ☐ NO ☐ ASA 1 ☐ ASA 2 ☐ Surgeon Signature:

OK to Book w RESTRICTIONS: ☐ **(Red Pen)**

Name:

Please fill out this questionnaire and hand it back to your Surgeon's medical office assistant. A copy will be sent to the hospital if you are booked for surgery to assist the physicians and nurses there who will be looking after you. It will remain a confidential part of your medical chart and will only be seen by those people involved in your care. **** *Failure to provide details as requested may delay your surgery.* ****

Do you have-- Or-- have you ever had any of the following: (check off boxes in either the No or Yes column)	**No**	**Yes**	**If-- YES, --it is *EXTREMELY IMPORTANT* to provide details in the space below. (i.e. Year of Event, Details of Event, Where Treated, Tests Done)**
Stroke (paralysis, weakness, numbness, visual problems on one side of your body)			
Epilepsy ☐ **Seizures** ☐ **Blackouts** ☐ ***Check all that apply**			
Severe Chest Pain ☐ **Angina** ☐ **Heart Attack** ☐ **Heart Failure** ☐ ***Check all that apply**			
Heart Surgery ☐ **Pacemaker** ☐ **Angioplasty** ☐ **Stent** ☐ **Blood Thinners** ☐ ***Check all that apply**			
Heart Murmur ☐ **Heart Valve problems** ☐ ***Check all that apply**			If yes, are antibiotics required prior to dental procedures? No ☐ Yes ☐
High Blood Pressure			
Irregular Heart Beat ☐ **Palpitations** ☐ **Requiring Blood Thinners** ☐ ***Check all that apply**			
Shortness of breath when Walking ☐ **Climbing Hills** ☐ **Climbing one flight of stairs** ☐ ***Check all that apply**			
What exercise do you do? What is your activity level?			
Asthma ☐ *If yes-please complete the questionnaire pg 4* **Emphysema** ☐ **COPD** ☐ ***Check all that apply**			
ICU admissions ☐ example = serious illnesses ☐ tracheotomies ☐ injuries ☐ ***check all that apply**			
Snore ☐ * **Sleep Apnea** ☐ *(If yes, complete the questionnaire pg 5)* *C-Pap machine ☐ Mouth Guard ☐ No treatment ☐			
Heartburn ☐ **Acid Reflux** ☐ **Stomach Ulcers** ☐ **Hiatus Hernia** ☐ ***Check all that apply**			
Diabetes **Type I** ☐ **Type II** ☐ Insulin Dependent ☐ Tablet ☐ Diet Controlled ☐			
Kidney ☐ **Bladder** ☐ **Prostate problems** ☐ **Liver problems** ☐ **Jaundice / Hepatitis** ☐ ***Check all that apply**			
Difficulty opening your mouth ☐ **Moving your neck** ☐ ***Check all that apply**			
Dentures ☐ **Capped Teeth** ☐ **Loose Teeth** ☐ **Bridges** ☐ ***Check all that apply**			
Serious problems / reactions to Anaesthetic Yourself ☐ Immediate family ☐ ***provide full details***			
Arthritis: Osteo ☐ **Rheumatoid** ☐ **Lupus** ☐			
Multiple Sclerosis			
Thyroid Disorder Now ☐ History of ☐			
Varicose Veins			
Pregnant			
Bleeding Disorders Yourself ☐ Immediate family ☐ ***Check all that apply** ***provide full details***			
Blood Clots: **Legs** ☐ **Lungs** ☐ ***Check all that apply** Yourself ☐ Immediate family ☐ ***provide full details***			
Antibiotic Resistant Organisms Now ☐ History of ☐ ARO ☐ MRSA ☐ VRE ☐ ***provide full details***			
Illnesses or Medical Problems that were not mentioned ***provide full details***			

Name:

Have you ever had any of the following?	No	Yes	Please provide ALL details so Results can be Obtained
Exercise Stress Test (Treadmill)			Year, Reason: Lab & City:
Nuclear Medicine Heart Scan (MIBI)			Year, Reason: Lab & City:
Heart Catheterization (angiogram)			Year, Reason: Lab & City:
Heart Echocardiogram (ultrasound of heart)			Year, Reason: Lab & City:
Holter Monitor			Year, Reason: Lab & City:
EKG			Year, Reason: Lab & City:
Lung Function test/pulmonary function test			Year, Reason: Lab & City:
Sleep Apnea Test			Year, Reason: Lab & City:
Have you ever seen a:	**No**	**Yes**	**Please provide ALL details so Results can be Obtained**
Cardiologist			Year: Reason: Dr, Clinic, City:
Respirologist			Year: Reason: Dr, Clinic, City:
Neurologist			Year: Reason: Dr, Clinic, City:
Other			Year: Reason: Dr, Clinic, City:

List ALL Previous Surgery			Previous Surgery - *PLEASE COMPLETE*		
Name of Surgery	Anaesthetic Used (Genera/Spinal/IV Sedation/Local)	Problems with Anaesthetic	Year	Hospital/Clinic	City/Prov.

Do you take any MEDICATIONS? **YES** ☐ **NO** ☐

Please list the **name** and **dosage** of **ALL MEDICATIONS** including **prescriptions** or **over the counter pills**, **inhalers**, **patches**, **vitamins** and **herbal supplements** and/or **steroids**.

Drug Name	Dosage (mg, etc.) Amount (1 tab)	How Often Taken (daily, 2 times a day)

Do you have any ALLERGIES? (Please include any food or drug allergies) **YES** ☐ **NO** ☐

Allergy	Reaction

Are you allergic to latex (rubber)? **YES** ☐ **NO** ☐ **Reaction:**

Name:			
	YES	**NO**	
Do you **Smoke**?			If YES, How much? _____ For how long?
Did you used to smoke?			If YES, How much? _____ For how long? When did you quit?
Do you use recreational drugs?			If YES, please specify:
Do you drink Alcohol?			If YES, How much in a week?

Smoking Questionnaire

Please complete if you have any history of smoking!

# of Cigarettes per day:_____ How Long:_____

Chronic Cough:_____ How Long: _____Dry: _____ Productive:_____

Chest Infections and Treatments
(Steroids/Inhalers):_____

_____

Any Shortness of Breath on Exertion:_____ Type of Work:_____

Can you climb 1 flight of stairs without shortness of Breath: YES: _____ NO:_____

Exercise-what can you do_____

Asthma Questionnaire

Please complete if you have any history of Asthma

Asthma medications: (Inhalers, Steroids, Etc.) Dosage, # of times used per day and when:

_____

_____

Ventolin use: Times used Wkly: _____ or Times Used Mthly_____ Reason for Use:_____

Asthma Triggers:_____

_____

Does breathing get worse with: Cold Air: Yes No Dust: Yes No Smoke: Yes No

Difficulty breathing (dyspnea) at night or in the early morning: Yes No

Hospitalizations due Asthma attack: Yes No **ER visits due to Asthma attack**: Yes No **Recent exacerbations**: Yes No

If Yes-Please provide details:_____

_____

Have you had a General Anaesthetic with Intubation? Yes No

If yes, any complications?_____

Name:

PAC SLEEP APNEA Questionnaire

Please complete if you answered yes to snoring!

(STOP-Bang Snore Model)

1.	Snoring: Do you snore loudly (loud enough to be heard through closed doors)?	Yes	No
2.	Tired: Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
3.	Observed: Has anyone observed 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: BMI more than 35?	Yes	No
6.	Age: Age over 50 years old?	Yes	No
7.	Neck circumference: Neck circumference greater than 40 cm (15 3/4")?	Yes	No
8.	Gender: Male?	Yes	No
		_____	_____
	Total Score:	Yes	No

For Anaesthesia only

High Risk OSA: Yes to 3 or more questions

Low Risk OSA: Yes to less than 3 questions

Covenant Health
Compassionate care led by Catholic values

Name (Last, First)	
Date of Birth (yyyy-Mon-dd)	
PHN#	HRN#

Consent to Disclose Health Information

The patient/client or his/her authorized representative must complete this form before the patient/client's health information may be disclosed to someone else (unless the *Health Information Act* allows for disclosure without consent).

Patient/Client Name (Last, First)			
Date of Birth (yyyy-Mon-dd)	Personal health number		
Address	City/Town	Province	Postal Code
Details of health information to be disclosed (Describe in full without abbreviations. Include dates of treatment)			
Describe where records are located (health service provider, hospital, clinic, program)		City/Town	
Name of person/organization information is to be disclosed to Banff Mineral Springs Hospital Pre Operative Assessment Clinic		Phone 403-760-7243	
Address 305 Lynx Street, Box 1050	City/Town Banff	Province AB	Postal Code T1L 1H7
Purpose of disclosure Pre Operative Assessment		Expiry date (yyyy-Mon-dd) *(valid for 2 years if no date)*	

Authority of person giving consent (If signing on behalf of the patient/client indicate your authority below and provide a copy of the document which authorizes you)

☐ Guardian(or Trustee)	-Of a minor under the age of 18 years who is not determined to be a mature minor -Named in a Guardianship Order/appointed under the *Adult Guardianship and Trusteeship Act*, if access to health information relates to the powers and Duties of the guardian (or trustee)
☐ Specific decision maker	-as defined in the *Adult Guardianship and Trusteeship Act*
☐ Agent	-appointed in an enacted personal directive according to the *Personal Directives Act*
☐ Personal representative	-of a deceased patient, if the access to information relates to administration of the individual's estate
☐ Nearest relative	-applies only to the nearest relative with obligations under the *Mental Health Act*
☐ Power of attorney	-if access to health information relates to the powers and duties of the attorney
☐ Written authorization	-a person with the patient/client's written authorization to act on the patient/client's behalf

Consent: I authorize Covenant Health to disclose the health information described above. I understand why I have been asked to disclose my health information. I am aware of the risks and benefits of consenting or refusing to consent to the disclosure of my health information to the person/organization specifiedabove. I understand that I may revoke this consent in writing at any time.

Name of person giving consent	Signature	Date (yyyy-Mon-dd)

The information on this form, together with any copy of a document authorizing a representative to act on behalf of the patient/client is collected under part 3 of the Health Information Act for the purpose of recording the patient/client's consent to the specified disclosure and will be filed on the patient/client's health record. For questions about this collection of information, contact the program area that provided you this form or the Chief Privacy Officer, Information and Privacy at 16940-87 Ave, Edmonton, AB, T5R 4H5 or call 1-866-254-8181.