Senior Surgical Care Program

my health, my options, my care

Our Senior Surgical Care Program is a service to help you think about your surgery and plan for your recovery.

It begins as an appointment with a physician who specializes in care for older adults (sometimes called a geriatrician). You will be asked to describe things like your:

- overall health goals
- physical health and activity level
- emotional and cognitive health
- home environment
- family or caregiver support available to you

This information will help your surgeon and our multidisciplinary team of experts – geriatricians, surgeons, anesthesiologists, nurses, physical therapists and social workers – design a care plan tailored to meet your needs and goals. This team is dedicated to providing you with personalized care that will help with your recovery and optimize your health after surgery.

What if I am not sure about having surgery?

If you are unsure about having surgery, the program can help you understand the pros and cons of surgery so that you can make the right decision for you.

Why is Senior Surgical Care important?

For many people, surgery is an infrequent and unfamiliar event – and each of us has unique physical and emotional abilities and needs. Looking ahead at the recovery process after surgery puts you in the driver's seat and can give you and your family peace of mind.

What do I do now?

Please complete this questionnaire at home and bring it with you to your appointment with our geriatric physician. If you would like more details, please contact your physician or the Health Education Department.

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Senior Surgical Care Program
Intake Questionnaire

Instructions: Please check the best response.

1. In the past year, how many times were you admitted to a hospital?

◯ 0 times ◯ 1-2 times ◯ 3+ times

2. In general, how would you describe your health?

◯ Excellent ◯ Very Good ◯ Good
◯ Fair ◯ Poor

3. Which of the following activities do you need help with?

◯ Shopping ◯ Meal Preparation
◯ Transportation ◯ Housekeeping
◯ Laundry ◯ Managing Money
◯ Telephone ◯ Taking Medications

4. When you need help, is there someone who is willing and able to meet your needs?

◯ Always ◯ Sometimes ◯ Never

Please specify:

◯ Spouse ◯ Children ◯ Other Relatives
◯ Friend ◯ Hired Help or Agency Persons

Check **Yes** or **No** for the questions below:	**Yes**	**No**
5. Do you use 5 or more different prescription medications on a regular basis?	◯	◯
6. At times, do you forget to take your prescriptions?	◯	◯
7. Have you recently lost weight such that your clothing has become looser?	◯	◯
8. Do you often feel sad or depressed?	◯	◯
9. Do you lose control of urine when you don't want to?	◯	◯

10. Do you have any problems with bowel movement?

Please check all that apply.

- ◯ Constipation
- ◯ Diarrhea
- ◯ Incontinence
- ◯ None

11. What is your current living arrangement?

Please check all that apply.

- ◯ Live alone
- ◯ Live with spouse
- ◯ Live with children
- ◯ Live with other relative
- ◯ Live with non-relative

12. What type of housing do you live in?

- ◯ My own home
- ◯ The home of a relative or friend
- ◯ Board and care home (retirement home)
- ◯ Nursing home
- ◯ Other

Check **Yes** or **No** for the questions below:	**Yes**	**No**
13. During the past 12 months, have you fallen all the way to the ground or fallen and hit an object (chair, table, etc.)?	◯	◯
14. Do you have any memory problems?	◯	◯
15. Do you have any problems with your vision?	◯	◯
a. If **yes**, do you wear glasses?	◯	◯
16. Do you have any problems with your hearing?	◯	◯
a. If **yes**, do you wear hearing aids?	◯	◯
17. Do you have dentures?	◯	◯
18. Do you have problems with swallowing?	◯	◯
19. Do you currently smoke?	◯	◯
20. Do you drink 2 or more alcoholic beverages five or more days a week?	◯	◯

21. As your care team, we want to make sure that we are always doing what is best to help you and your health.

Please use the space below to:

- Explain your overall health goals and priorities
- Tell us what you would like to achieve with surgery
- Describe activities that are so important to you that you cannot imagine living without them

22. Please provide the information listed below.

Your Name:_____

Your Medical Record Number:_____

Your Primary Care Physician:_____

If you do not have an Advanced Health Care Directive on file, please visit kp.org/lifecareplan to download and complete your form today. Additional information and resources are available by visiting this website.