Harmony
SURGERY CENTER
2127 East Harmony Road, Suite 200 · Fort Collins, CO 80528
(970) 297-6300 · www.harmonyasc.com

PRE-OPERATIVE INSTRUCTIONS FOR SURGERY AT HARMONY SURGERY CENTER

Date & Time of Procedure:_____ **Please arrive at the Harmony Surgery Center 1 HOUR prior to your scheduled surgery time. CHECK-IN TIME:_____

Follow the instructions below STRICTLY for eating and drinking prior to your appointment.

*******For your safety, failure to follow these instructions will result in cancelation of your procedure. *******

STOP eating and drinking ALL food and liquids except for water, clear soda or apple juice **8 hours** before your arrival to Harmony Surgery Center, and then STOP drinking all water, clear soda and apple juice **2 hours** prior to your check-in time. This includes gum, mints, chewing tobacco, etc. **EXCEPTION: See note below if you take any GLP-1 medications.**

Pediatric Patients: Follow all above instructions except if breastfeeding - must stop feedings 4 hours prior to arrival or if using formula - must stop all feedings 6 hours prior to arrival.

NOTE: If you currently take any GLP-1 medications (semaglutide, Ozempic, Trulicity, Wegovy, etc.) you must not have any solid food intake for 24 hours prior to your procedure. You may only have clear liquids for the full 24 hours before procedure. STOP all clear liquids 4 hours prior to check-in time.

- Your doctor will advise you whether or not to take your regular medications. If you are told to take the medications, take them with a **small sip of water. **You must check with your provider for all medications, especially blood thinners. Continuation of blood thinners may result in cancellation of your procedure.**
- Notify your surgeon if you develop symptoms of cold, fever or other illness, as it may be necessary to postpone your procedure.
- If you have a Medical Power of Attorney or a Legal Guardian, you **must** bring a signed copy of the forms for our records. The guardian/Power of Attorney must be reachable by phone on the day of the procedure.
- **You must arrange for a ride home in advance!** You will not be permitted to drive or take a cab home. You cannot leave the facility alone. You can only be released in the care of a capable, responsible adult **(must be 18 years of age or older)** who must sign for you and accompany you home. A ride service is not a viable option as they will not take responsibility for your care at home.
- Please bring a book or something to keep you busy. You will have time waiting while in the facility.
- You will receive medications that alter your perception of time. Therefore, after your surgery, you may feel rushed. We will not send you home before it is safe for you to leave the Surgery Center. Expect to be discharged 60 minutes after your surgery.
- Your family/friend taking you home should plan on staying in the facility. We request that they do not leave during your procedure.
- Leave all jewelry and valuables at home. The Surgery Center cannot be held responsible for them.
- For pediatric patients, it is recommended for a family member to sit with the child in the back seat for the ride home.

***If you have any questions, please contact a nurse at 970-297-6303. We look forward to seeing you!**

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Scheduling Worksheet

Physician's Office Information

Physician Name: _____ ***Scheduler Name & Phone #***: _____

Surgery Date: _____ ***Length of Procedure***: _____ ***Start Time***: _____

CPT Codes: _____ ***ICD-10 Codes***: _____

If using Injury Diagnosis Code, need injury date.

Planned Procedures: _____

Patient's BMI:_____ **If BMI is over 50, please refer case to the hospital.**

Patient Has: ☐**Pacemaker** ☐**Defibrillator** If so please include a copy of the patients Cardiac Rhythm Management Devices (CRMD) card when scheduling. For patient safety we need the make and model so we can notify the representative to be here during the procedure.

Patient Information

Needs Interpreter?:☐Yes☐No **Language?**:_____

Patient's Name:_____ ***Sex***:☐M☐F ***DOB***: _____ **Under 18** ☐Y ☐N

Primary Phone #: _____ **Email:** _____ **Last 4 Digits of SS#:** _____

Responsible Party Name (if pt < 18): _____ ***Relationship:*** _____

Address: _____ ***Apt/Unit #***_____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Does the Patient live in a Skilled Nursing Facility? ☐***Y*** ☐***N*** ***If YES: Name of Facility:*** _____

Address of Facility: _____

Insurance Information

☐Self-Pay ☐Cosmetic ☐Auto ☐Work Comp (if Auto or W/C, Date of Injury:_____)

Insurance Carrier: _____ ***Insurance ID # or Claim #:*** _____

Claim Office Address: _____ ***Pre-Authorization #:*** _____

Subscriber Name: _____ ***Subscriber's DOB:*** _____ ***Relationship to patient:*** _____

Secondary Insurance: _____ ***Address:*** _____ ***ID#:*** _____

*Please authorize all procedures & implants (call if you need HCPCS codes for implants)
*HSC is out of network for some Cigna plans, please verify in network status before scheduling
*Self-pay & Cosmetic cases require payment in full prior to procedure. Please schedule at least 10 days in advance.

Special Requests

Type of Anesthesia (check one): ☐General ☐MAC ☐Local-Local **(HSC Nurse Monitored- NO Anesthesia Provider Present)**

Anesthesia Special Requests/Regional Blocks: _____

Overnight Stay: ☐Y ☐N *** Must be discharged in <24 hours.** ***Pathology Required (check one)***: ☐Routine to PVH ☐Stat to PVH

Special Equipment Needed: _____

Implants Requested: _____

Additional notes pertaining to patient or the case: _____

Important HSC Information:

Please send scheduling information in a secure email to Jamie.Mullen@uchealth.org and Nico.Noe-Daley@uchealth.org
Required information is in BOLD and ITALICS. If you have a copy of the insurance card, please include it.
Additional information required 72 hours prior to the case: patient consent, pre/post-op orders and the H&P. This can be sent to Justin at Jared.Wright@uchealth.org

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Pre-Op Admit Orders

Patient Name:_____ Patient Weight:_____ Surgery Date:_____

Physician:_____ DX or Procedure:_____

Allergies

❑ NKDA

Pre-Op Prep

❑ Hair Removal:_____ ❑ Scrub: _____Betadine _____Hibiclens _____Prevail _____ Other:_____

DVT Prophylaxis

☐ Apply venous pressure pumps prior to surgery

☐ Do not apply DVT prophylaxis

Collaborative Practice: All patients scheduled for cases ≥90 minutes are to have venous pressure pumps applied prior to surgery unless ordered otherwise.

Prophylactic Antibiotic Orders

☐ **NO ANTIBIOTICS ORDERED**

	Surgical Procedure Category	Recommended Antimicrobial	Adult Dose	Redose Interval		Antimicrobial Prophylaxis for B-Lactam Allergies	Adult dose	Redose Interval
☐	**Orthopedic/Plastic/ Podiatry/ Urology**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Vancomycin	<90kg – 1 gm ≥90kg – 1.5 gm	NA
☐	**Gastroduodenal**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Ciprofloxacin **+** Clindamycin	400 mg 900 mg	NA 6 hrs
☐	**Biliary Tract**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Ciprofloxacin **+** Metronidazole	400 mg 500 mg	NA
☐	**Hernia Repair**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Vancomycin	<90kg – 1 gm ≥90kg – 1.5 gm	NA
☐	**Colorectal/Appendectomy**	Cefazolin **+** Metronidazole OR Cefoxitin	2gm (<120kg) 3gm (≥120kg) 500 mg 2 gm	4 hrs NA 2 hrs	**OR**	Ciprofloxacin **+** Metronidazole	400 mg 500 mg	NA NA
☐	**Head & Neck: Clean with placement of prosthesis**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Clindamycin **+/-** Gentamycin	900 mg 5 mg/kg	6 hrs NA
☐	**Head & Neck: Clean-Contaminated**	Cefazolin **+** Metronidazole	2gm (<120kg) 3gm (≥120kg) 500 mg	4 hrs NA	**OR**	Clindamycin **+/-** Gentamycin	900 mg 5 mg/kg	6 hrs NA
☐	**Intrathecal Pumps**	Cefazolin	2gm (<120kg) 3gm (≥120kg)	4 hrs	**OR**	Vancomycin	<90kg – 1 gm ≥90kg – 1.5 gm	NA
☐	**Pediatric Patients**	Cefazolin	_____ mg/kg up to _____ mg		**OR**			
☐	**Other**							

Additional Day of Surgery Orders

Physician Signature _____ Date _____ Time _____

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CONSENT FOR SURGERY OR OTHER PROCEDURE

SURGERY OR OTHER PROCEDURE: I, _____ permit Dr. _____ / Assistant_____(as needed) and any other doctors or assistants needed to assist in performing the surgery/procedure my doctor has recommended. An assistant may perform one or all of the following tasks under the supervision of my primary surgeon: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. The surgery procedure my doctor has recommended is: _____

_____

_____

THIS SURGERY OR PROCEDURE HAS BEEN RECOMMENDED BECAUSE:

_____

MY OTHER TREATMENT OPTIONS INCLUDE: _____

I acknowledge that I have read and understand the following risks related to anesthesia. By signing this consent, I allow the use of any anesthetics, sedatives or other medications as directed by my surgeon, anesthesiologist, or certified nurse anesthetist working under the direction of an anesthesiologist that may be necessary. I understand that the administration of anesthesia, including sedation, carries with it certain risks above and beyond those relating to the procedure itself. These risks include, but are not limited to: respiratory (breathing) problems; blood pressure problems; irregular heart beat; irritability; nausea and vomiting; prolonged drowsiness; damage to teeth and/or dental work; unsteadiness; failure to achieve adequate sedation and/or possible awareness or memory of the procedure; allergic or unexpected and possibly severe drug reactions; nerve damage; extended hospital stay and death.

I UNDERSTAND THAT:

- Any surgery or procedure and the use of anesthesia have some risks. These risks can be serious and in rare cases result in death.
- Treatment results are not guaranteed and may not cure the condition.
- I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my physician(s).
- Medical students may participate in my surgical care under the direct supervision of my physician(s).
- I consent to the disposal of any human tissue or body part which may be removed during the surgery / procedure(s).
- The risks listed below are the more common risks, but are not all the possible risks associated with this operation or procedure.

RISKS: The most common risks are bleeding, infection, nerve injury, blood clots, heart attack, allergic reactions, and pneumonia. Other risks of this particular operation or procedure include: Bleeding; Infection; Persistent Incontinence; Urinary Retention with need for catheter; Irritation, urgency or frequency; Reaction to sling material (inflammation, infection or allergic); Erosion of sling material into urethra; Discomfort from pulling of sutures; Discomfort with sexual intercourse; Thigh Pain; Damage to adjacent structures (bladder, ureter(s), rectum, etc.); blood vessels or nerves; Need for further treatment____

_____

Your physician and anesthesia provider are not employees of the Center; they are agents of you. The Surgery Center is responsible for and provides supportive nursing and procedural services. The Surgery Center is not responsible for actions of the surgeon or anesthesia providers.

If during my surgery the doctor finds an unanticipated medical need, I permit him/her to provide the necessary treatment(s). My doctor has fully explained the surgical procedure in words I understand, I have read and fully understand this consent form, and all of my questions have been answered. Do not sign unless you have read and thoroughly understand this form.

Patient/Responsible Party_____ Date_____

Witness_____ Date_____

Physician_____ Date_____

HARMONY SURGERY CENTER, LLC

Patient Admission Assessment Form

Allergies (medications, latex, products):

☐ None

Do you or your responsible party need information on the following (circle needs)? None Medications Procedures Current Illness Follow-up care Diet/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment

Preferred Learning Method (circle)? None Listening Demonstration Reading Hands-on Other:

Barriers/Health Related Social Needs (circle): None Cognitive Hearing Education/Literacy Language Transportation Vision Emotional Physical Food or Housing Insecurity Other:

Pain Evaluation: Current Pain? ☐ Yes ☐ No If yes: Pain level (1-10)_____ Location:
Description (circle): Dull Sharp Burning Aching Current pain treatment:

Please list any belongings you have with you:
Note: HSC is not responsible for belongings. Please give all valuables to your ride home.

Who is taking you home today? (It is recommended you have a responsible adult with you for 24 hours after procedure**):**

Name of Ride: _____ **Phone Number:** _____
**Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride? ☐ Yes ☐ No

Health History:	Yes	No
Seizure/stroke or other neurological problem? Describe:		
Problems with your heart? Describe:		
Chest pressure, chest pain?		
Shortness of breath with exertion or exercise?		
❑ Pacemaker ❑ defibrillator		
❑Cardiac stent ❑ blood vessel stent ❑cardiac bypass		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)? Last Dose:		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Supplemental oxygen?		
Do you currently❑smoke ❑Vape ❑Tobacco products:		
Have you ever smoked? When did you quit?		
Sleep apnea ❑CPAP ❑ Oxygen at night		
Kidney problems?		
Gastrointestinal problems?		
Frequent heartburn?		
Liver problems?		
Diarrhea or abdominal cramping? For how long?		
Diabetes and/or high blood sugar?		
❑Thyroid ❑Parathyroid ❑ adrenal gland problems		
Cancer:		
Have you had surgery on any of the following? ☐Heart ☐Brain/Spine ☐Transplant ☐Implants		

	Yes	No
Have you been hospitalized in the last 90 days? Describe:		
Currently have a contagious or infectious condition? Describe:		
Illness, infection or fever in the past 2 weeks?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from: ☐ anxiety ☐ depression ☐ PTSD and/or ☐ panic attacks		
Do you smoke or consume marijuana? Last used:		
Do you use recreational drugs? Last used:		
Drink alcohol? ☐ Daily ☐ Weekly		
❑ Dentures or problems with your teeth?		
Eye or vision problems? ☐Glasses ☐Contacts		
Hearing problems? Hearing Aids ❑		
Use ☐ wheelchair ☐ walker ☐cane		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)? Describe:		
Any concerns about anesthesia? Describe:		
Is there any possibility you could be pregnant? ☐N/A		
Date of your last menstrual period? ☐N/A		
❑Currently breastfeeding ❑ N/A		
Circle if applicable: Menopausal❑ Hysterectomy❑		
Do you have an Advance Directive: ❑ CPR Directive ❑ Living Will ❑ Power of Attorney ❑ Other		
Who is your Primary Care Doctor?		
Height: **Weight:**		
Signature of patient or person completing form: **X**		

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Medication Reconciliation Form

****Please list all medications on this form. We are NOT able to accept a copy of your medications****

Patient: Please list all medications taken on a regular basis (including over the counter and herbal preparations).

Medication Name	Dose	Route	Frequency	Last Taken	RN to complete: Continue after discharge OR refer to prescribing physician: CONTINUE	REFER to MD
1.					❑	❑
2.					❑	❑
3.					❑	❑
4.					❑	❑
5.					❑	❑
6.					❑	❑
7.					❑	❑
8.					❑	❑
9.					❑	❑
10.					❑	❑
11.					❑	❑
12.					❑	❑
13.					❑	❑
14.					❑	❑

New Prescriptions Prescribed at HSC	Dose	Route	Frequency	Last Taken	Use
1.					
2.					
3.					
4.					

I will be provided with a copy of this list upon discharge. Please note, all routine medications marked "REFER to MD" should be clarified with the prescribing physician before continuing. **Medication Safety:** To safely manage routine and new medications, it is important to give a copy of your Medication Reconciliation Form to your primary care physician. It is also important to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added.

Patient/Responsible Party Signature:_____ Date:_____

RN Signature: _____Date:_____

Patient Identification

Important Billing Information ...

As you prepare for your procedure, we want to make sure you understand how you will be billed for the services you receive. At a minimum, you will receive three separate bills. The success of your procedure depends on a team effort by many dedicated professionals, including those in our Center. Because government and insurance rules do not permit us to bill or collect money for team members, each member must send you a separate bill and collect payment from you separately.

Surgery Center's Bill: You will get a bill from us for the facility fee. This fee is for the staff, supplies, equipment and medications we provide for your safe and successful experience here.

Physician's Bill: Since the physician performing your surgery is not an employee of the Center, he will bill you separately for his services. The physician's bill will be sent from the physician's office for performing the procedure.

Anesthesia Bill: The anesthesia you receive during your procedure will be provided by a certified registered nurse anesthetist and/or an anesthesiologist and you will be monitored throughout the procedure. Please call 970-224-2985 if you have questions regarding anesthesia.

Other Bills: Depending on several factors related to your procedure, you may receive services and additional bills which may include:

- **Laboratory Bill:** Which may include fees for blood or urine tests.

- **Pathology Bill:** Which may include testing of any tissue samples taken during the procedure – pathology results will be available from your physican's office 7-10 days after your procedure.

Our staff will do their very best to help you with questions and guide you to the proper sources of information. Please contact your insurance company in advance to verify network status, benefits and facility coverage. If you have any questions about this information, please contact us at (970) 297-6435, (970) 297-6454 or (970) 297-6449. Thank you!