Harmony SURGERY CENTER

Scheduling Worksheet

Physician's Office Information

Physician Name: _______________________________ ***Surgeon/Medical Student Assist***: ____________________________

Referring Physician: ___________________________ ***Contact Person***:_____________________***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

Patient Speaks: Spanish □ English □ Both □

Patient's Name:____ ***Sex***: M F ***DOB***: ____________ **Under 18** Y N

Last 4 Digit of SS#:____

Responsible Party Name (if pt < 18):______________________________________ Relationship:___________________________

Email:_______________________ Home Phone #:_________________________ Work Phone #:__________________________

Address: _____________________________Apt/Unit #________City:______________________State:__________Zip__________

Does Patient live in a Skilled Nursing Facility: Y N If YES – **Name of Facility**:_____________________________________

SNF Address: ____

Insurance Information

Insurance Carrier: ____***Cardholder Name***:_________________________________

Card Holder's DOB: ____***Insurance ID #***: ___________________________________

Pre-Authorization #:_________________________________

*FYI – **Cigna's** new policy updates now require pre authorizations on almost all procedures and implants (call if you would like a copy of the pre auth list). **BC/BS** has also updated their Medical Necessity Requirements.*

Work Comp Carrier:____________________________________ ***Claim Adjuster Name***: ________________________________

Date of Injury________________ **WC Case #:** _______________________________ ***WC Auth #***: _________________________

Special Requests

Type of Anesthesia (circle 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 (circle one)***: Routine to PVH Stat to PVH

Special Equipment Needed: ____

Implants Requested: ____

Additional notes pertaining to patient or the case: ____

Important HSC Information

At the time of scheduling please fax a copy of the scheduling worksheet and insurance card.

Required information is in BOLD and ITALICS. If the information is not completed, please expect a phone call from one of our schedulers.

Additional information required 72 hours prior to the case; patient consent, pre/post-op orders and the H&P. Please fax to (970) 297-6330.

Harmony SURGERY CENTER

Pre-Op Admit Orders

Patient Name:________________________ Patient Weight:__________ Surgery Date:______________
Physician:________________________ DX or Procedure:________________________

Allergies

❑ NKDA

Laboratory

❑ CBC ❑ PT/INR ❑ BMP ❑ Urine HCG ❑Other:

Cardiovascular/X-Ray

❑ EKG: _____To be read by Cardiologist _____ Used as Baseline ❑ CXR ❑ Other:______________________________

Pre-Op Prep

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

DVT Prophylaxis

❑Venous Pressure Pumps ❑ Low-Risk Patient/Procedure – NO DVT Prophylaxis ❑ Ted Hose: Thigh High or Knee High

Prophylactic Antibiotic Orders

Severe Penicillin allergy or cephalosporin allergy (hives, shortness of breath, laryngeal edema, and/or anaphylaxis)
❑ Yes or ❑ No

NOTE: Adult Indications for using Vancomycin Physician/APN/PA/Pharmacist documentation of MRSA; High risk due to acute hospitalization within the last year; High risk due to stay in long-term care facility within last year (prior to this admission); Physician/APN/PA/Pharmacist documentation of increased MRSA rate associated with the procedure; Chronic wound care or dialysis; Other physician/APN/PA/Pharmacist documented reason ______________________________

Surgery		Medication	Administer within:	Redose during procedure
Hip/Knee Arthroplasty Orthopedic/Podiatry	**Adult:**	❑Cefazolin		
		❑ For patients ≤ 80 kg, 1 gm IV	60 mins prior to incision	4 hrs
		❑ For patients > 80 kg, 2gm IV	60 mins prior to incision	4 hrs
		If severe penicillin or cephalosporin allergy administer:		
		❑ Clindamycin 600mg IV	60 mins prior to incision	4 hrs
		❑ Vancomycin 1gm IV (admin over 1 hr)	2 hours prior to incision	8 hrs
	Pediatric:	❑ Ancef _______ mg/kg up to ___________ mg	60 mins prior to incision	Per Physician
		❑ Other: ______________________		
Genitourinary Transrectal Prostate	**Adult:**	❑ Levofloxacin 500mg IV (admin over 1 hr)	2 hours prior to incision	Single-dose only
		❑ Clindamycin 600mg IV **AND** Gentamicin 100mg IV	60 mins prior to incision	4 hrs
		❑ Metronidazole 500 mg IV **AND** Gentamicin 100mg IV	60 mins prior to incision	6 hrs
	Pediatric:	❑ Ancef _______ mg/kg up to ___________ mg	60 mins prior to incision	Per Physician
		❑ Other: ______________________		
Head and Neck	**Adult:**	❑ Cefazolin		
		❑ For patients ≤ 80 kg, 1 gm IV	60 mins prior to incision	4 hrs
		❑ For patients > 80 kg, 2gm IV	60 mins prior to incision	4 hrs
		If severe penicillin or cephalosporin allergy administer:		
		❑ Clindamycin 600mg IV	60 mins prior to incision	4 hrs
	Pediatric:	❑ Ancef _______ mg/kg up to ___________ mg	60 mins prior to incision	Per Physician
		❑ Other: ______________________		
Other Surgeries	**Adult:**	❑ Cefazolin		
		❑ For patients ≤ 80 kg, 1 gm IV	60 mins prior to incision	4 hrs
		❑ For patients > 80 kg, 2gm IV	60 mins prior to incision	4 hrs
		❑ Cefoxitin 2gm IV	60 mins prior to incision	2 hrs
	*******If allergic to PCN, give:**	❑ Clindamycin 600mg IV	60 mins prior to incision	4 hrs
		❑ Vancomycin 1gm IV (admin over 1 hr)	2 hours prior to incision	8 hrs
		❑ Metronidazole 500mg IV	60 mins prior to incision	6 hrs
		❑ Levofloxacin 500mg IV (admin over 1 hr)	2 hours prior to incision	Single-dose only
	Pediatric:	❑ Ancef _______ mg/kg up to ___________ mg	60 mins prior to incision	Per Physician
		❑ Other: ______________________		

Additional Day of Surgery Orders

_________________________ _____________ ___________
Physician Signature Date Time

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:

____________ **Right / Left** ____

____

____

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: ____

____

____

SURGERY PATIENTS:

If during my surgery the doctor finds an unsuspected 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______________ Time______________

Witness____ Date______________ Time______________

Physician____ Date______________ Time______________

CONSENT FOR SURGERY
OR OTHER PROCEDURE

Patient Identification

TRANSFUSION CONSENT

BLOOD TRANSFUSIONS

I also understand that I may need to receive blood or blood products while I am in the facility. I understand there are several options I may consider in receiving blood. I may have:

- Blood donated by myself for my own use (self-donated blood).
- Blood donated by friend or family for my use (directed donors).
- Blood currently available to the hospital from other donors (banked blood).
- Other sources are:____

I UNDERSTAND SOME OF THE COMMON RISKS OF RECEIVING BLOOD OR BLOOD PRODUCTS ARE:

- getting an infectious disease (such as hepatitis or AIDS)
- bad reactions such as: fever, hives, high blood pressure, shortness of breath, and heart or kidney problems.

I UNDERSTAND THAT:

- Results of blood transfusions are not always successful and that guarantees cannot be made that the transfusion will help me.
- Losing large amounts of blood may result in death, if blood is not replaced.
- All donors are carefully screened, and all blood is tested thoroughly and properly.
- Blood donated directly for my use by friends or family has NOT been shown to be safer than banked blood.
- If blood I donated to be given back to myself tests positive for AIDS or hepatitis, it will be discarded to protect the health care workers from the hospital.
- If there is not enough donated blood for my use (either self or directed donations), blood from the Blood Bank will be used.
- This consent to blood transfusion(s) is effective throughout this admission.

My doctor has fully explained the possibility of blood transfusion 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______________ Time ______________

Witness____ Date______________ Time ______________

Physician____ Date______________ Time ______________

I refuse to receive blood or blood products for any reason. My doctor has explained the likely complications that may occur if I need blood and do not receive it. I will accept all risks associated with my refusal to receive blood and will release my doctor and Harmony Surgery Center, LLC, from any responsibility for any bad results, including my death, which may occur because I refused to accept blood or a blood product.

____________________(Please put your initials here if refusing blood or blood products.)

Patient Identification

CONSENT FOR SURGERY
OR OTHER PROCEDURE

Short Form History and Physical

INDICATIONS/SYMPTOMS:____

____

____

PAST MEDICAL HISTORY,
FAMILY & SOCIAL HISTORY:____

____

____

EXISTING COMORBID CONDITIONS:____

____

____

DRUG ALLERGIES:____

____

MEDICATIONS, DOSAGE & FREQUENCY:____

____

PHYSICAL EXAMINATION: **BP:**________________ **PULSE:**________________

NORMAL **COMMENTS**

☐ **MENTAL STATUS:** ____

☐ **LUNGS:**____

☐ **HEART:**____

☐ **EXAM SPECIFIC TO PROPOSED PROCEDURE:**____

____

☐ **PATIENT'S GENERAL CONDITION:**____

____

ASSESSMENT AND PLAN:____

____

Patient Identification

____
PHYSICIAN SIGNATURE DATE

White – Medical Records; Yellow – Physician's Office

HARMONY SURGERY CENTER, LLC

Patient Admission Assessment Form

PATIENT: PLEASE BEGIN HERE AND COMPLETE THE INFORMATION BELOW
List your allergies to Medicines, Latex (rubber), Food, Tape, Other:
List your previous surgeries/hospitalizations:
Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride home? ❑ Yes ❑ No
Name and phone number of ride home (note - patient is advised to have a responsible adult with them for 24 hours after procedure):
Who is your Primary Care Physician:

Health History:	**Yes**	**No**
Height:___________ **Weight:**___________		
Seizure/stroke or other neurological problem?		
Problems with your heart?		
Chest pressure, chest pain?		
Shortness of breath with exertion or exercise?		
Pacemaker or defibrillator?		
Cardiac stent/blood vessel stent or cardiac bypass?		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin®, Aleve®, etc.)?		
Blood disorder?		
Autoimmune disorder?		
Lung problems or problems breathing?		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
Sleep apnea?		
Kidney problems?		
Gastrointestinal or liver problems?		
Diarrhea and/or abdominal cramping? For how long?		
Thyroid, Parathyroid, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
Currently have a contagious or infectious condition?		
Illness, infection or fever in the past 2 weeks?		
Diabetes and/or high blood sugar?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from anxiety, nervousness, or panic attacks?		
Mental health concerns?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? Frequency?		
Dentures or problems with your teeth?		
Eye or vision problems?		

Health History Continued:	**Yes**	**No**
Hearing problems?		
Physical restrictions?		
Frequent heartburn?		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)?		
Any concerns about anesthesia?		
Is there **any** possibility you could be pregnant?		
Currently breastfeeding?		
Date of your last menstrual period?		
Do you have an advance directive: ❑ CPR Directive ❑ Living Will ❑ Power of Attorney ❑ Other		
Do you have someone who can help you at home if needed?		
Do you have any anticipated discharge needs?		

Belongings

Please list any belongings you have with you upon admission to HSC

❑ Wallet ❑ Purse ❑ Rings ❑ Glasses ❑Other:
❑ Phone ❑ Piercings ❑ Dentures ❑ Hearing Aid(s)

Note: HSC cannot be responsible for belongings. Please give valuables to your ride home.

Education Assessment

Do you or your responsible party need information on the following?

❑ None ❑ Rehab Techniques
❑ Medications ❑ Treatment/Procedures
❑ Current Illness ❑ Access to follow-up care
❑ Diet/Nutrition ❑ Personal Hygiene/Grooming/Oral Care
❑ Home Care ❑ Community Resources
❑ Equipment ❑ Other

Preferred Learning Method:

❑ Listening ❑ Demonstrations ❑ Videos
❑ Reading ❑ Hands-On ❑ None

Barriers: Check all that apply

❑ None ❑ Language ❑ Physical
❑ Cognitive ❑ Culture ❑ Financial
❑ Hearing ❑ Vision ❑ Desire/Motivation
❑ Read/Write ❑ Emotional ❑ Religion
❑ Other:

Pain Evaluation

Pain: ❑ Yes ❑ No **If yes, please complete the following:**
Pain Level (1-10)_______ Location:____________________________________
Onset/Duration:____
Description: ❑ Dull ❑ Sharp ❑ Burning ❑ Aching
Current pain treatment: ❑ Meds ❑ Ice ❑ Elevation
❑ Heat ❑ Massage ❑ Other:

Signature of patient or person completing form:

X

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