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 & Address of Facility**: _____

Does this Patient have a Medical POA or Legal Guardian? ☐ Y ☐ N **If YES- Paperwork is required at the time of scheduling***

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 (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

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.

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

Harmony
SURGERY CENTER

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: **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, pneumonia and death. Other risks of this particular operation or procedure include: _____

_____

_____

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_____ Time_____

Witness_____ Date_____ Time_____

Physician_____ Date_____ Time_____

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

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

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?		

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