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

To prepare yourself for your upcoming procedure, please follow the instructions given below.
Please read them *carefully*!

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

- Please visit our website at www.harmonyasc.com . Click on the Patient Forms tab at the top of the page and fill out the Health History and Medication List forms. Please submit these forms electronically prior to your date of service. *If you do not have online access, these forms will be available for you to fill out on your procedure date.*
- If you need directions to our facility, please visit our website at www.harmonyasc.com
- Please **bring your insurance card and photo ID with you**. Please bring your eye glasses with you.

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.

1. 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
2. STOP drinking all water, clear soda and apple juice **2 hours** prior to your arrival.
3. **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.

- Your doctor will advise you whether or not to take your regular medications. If you take the medications, take them with a **small sip of water.**
- If you use a CPAP machine at home, please bring it with you.
- Notify your surgeon if you develop symptoms of cold, fever or other illness, as it may be necessary to postpone your procedure.
- Remove make-up and nail polish. Shower the morning of surgery, your physician may also have you perform other cleansing preparations before you arrive for surgery. If having hand surgery, you must remove artificial nails.
- If you have a Medical Power of Attorney of a Legal Guardian, you **must** bring a signed copy of the forms for our records.
- **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.
- 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.
- 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!**

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

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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

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 documented 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	**Adult:**	❑Cefazolin		
Orthopedic/Podiatry		❑ 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	**Adult:**	❑ Levofloxacin 500mg IV (admin over 1 hr)	2 hours prior to incision	Single-dose only
Transrectal Prostate		❑ 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

Important Billing Information…

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. Depending on your specific procedure, you may also get additional 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 physician'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)297-6449, (970)297-6435 or (970)297-6454. Thank you!

How to find us: