

INSTRUCTIONS FOR SURGERY/PROCEDURES AT HARMONY SURGERY CENTER
To prepare yourself for your upcoming procedure, please follow the instructions given below.
Please read them carefully!

****Please arrive at the Harmony Surgery Center 1 HOUR prior to your scheduled surgery/procedure time.**

FOR SURGICAL & PAIN PROCEDURE PATIENTS: 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.**

FOR GI PATIENTS (COLONOSCOPY/UPPER ENDOSCOPY/EGD): Follow the specific instructions for the Prep you were previously given. Prep instructions are also located on the HarmonyASC.com website for your reference.

ADDITIONAL INSTRUCTIONS FOR ALL PATIENTS:

Your doctor will advise you whether or not to take your regular medications. If you are instructed to take the medications, take them with a **small sip of water**. ****If you take blood thinners/anticoagulants, make sure you strictly follow the instructions given by your doctor for stopping these medications. If you did not receive instructions, contact your doctor right away.**

****Please go online to harmonyasc.com and fill out your Online Registration. Please submit this **prior** to your date of service. **PLEASE FILL OUT YOUR ONLINE REGISTRATION BEFORE YOUR PROCEDURE BY GOING TO:****

harmonyasc.com

Click on the "Patient Registration" button at the top of the page

New Patient Password: **HSC970NEW**

Please follow prompts and answer all of the questions.

Please **bring your insurance card and photo ID with you**. Please bring your eye glasses 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. **You must remove artificial nails**. Shower the morning of surgery, your physician may also have you perform other cleansing preparations before you arrive for surgery.

If you have a Medical Power of Attorney or a Legal Guardian, you **must** bring a signed copy of the forms for our records.

If you use a CPAP machine at home, please bring it with you (**SURGICAL PATIENTS ONLY**). ****Continued on next page**

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. If you do not have a responsible adult able to sign you out and take you home, your procedure will be cancelled.**

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.

Harmony Surgery Center is located at:

2127 East Harmony Road, Suite 200

Fort Collins, CO 80528

Reception: (970) 297-6300

If you need directions to our facility, please visit our website at www.harmonyasc.com

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

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

- 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.

Multimodal Medication Orders

Multimodal Medications for **NON-Bariatric** Cases:

1. Pepcid 20mg IV x 1
2. Tylenol 1000mg PO x 1 (hold for severe liver disease or cirrhosis)
3. Gabapentin 300mg – 600mg PO x1 (hold if allergic or if patient already took their own dose morning of surgery)
4. Celebrex 400mg PO x 1 (hold if allergic or if patient already took their own dose of Celebrex or any other NSAID morning of surgery)

Multimodal Medications for **Bariatric** Cases:

1. Tylenol 1000mg po x1(open capsule and mix with gabapentin oral solution immediately prior to administration) (hold for severe liver disease or cirrhosis)
2. Gabapentin 50mg/ml oral solution 300-600mg (6-12ml) (hold if allergic or if patient already took their own dose morning of surgery)
3. Celebrex 400mg (open capsule and mix with gabapentin oral solution immediately prior to administration) 1 (hold if allergic or if patient already took their own dose of Celebrex or any other NSAID morning of surgery)

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
<input type="checkbox"/>	ORTHOPEDIC/PLASTIC/ PODIATRY/ UROLOGY	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Vancomycin	<90kg – 1 gm ≥ 90 kg – 1.5 gm	NA
<input type="checkbox"/>	GASTRODUODENAL	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Ciprofloxacin + Clindamycin	400 mg 900 mg	NA 6 hrs
<input type="checkbox"/>	BILIARY TRACT	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Ciprofloxacin + Metronidazole	400 mg 500 mg	NA
<input type="checkbox"/>	HERNIA REPAIR	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Vancomycin	<90kg – 1 gm ≥ 90 kg – 1.5 gm	NA
<input type="checkbox"/>	COLORECTAL/APPENDECTOMY	Cefazolin + Metronidazole OR Cefoxitin	2gm (<120kg) 3gm (≥ 120 kg) 500 mg 2 gm	4 hrs NA 2 hrs	OR	Ciprofloxacin + Metronidazole	400 mg 500 mg	NA NA
<input type="checkbox"/>	HEAD & NECK: CLEAN WITH PLACEMENT OF PROSTHESIS	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Clindamycin +/- Gentamycin	900 mg 5 mg/kg	6 hrs NA
<input type="checkbox"/>	HEAD & NECK: CLEAN- CONTAMINATED	Cefazolin + Metronidazole	2gm (<120kg) 3gm (≥ 120 kg) 500 mg	4 hrs NA	OR	Clindamycin +/- Gentamycin	900 mg 5 mg/kg	6 hrs NA
<input type="checkbox"/>	INTRATHECAL PUMPS	Cefazolin	2gm (<120kg) 3gm (≥ 120 kg)	4 hrs	OR	Vancomycin	<90kg – 1 gm ≥ 90 kg – 1.5 gm	NA
<input type="checkbox"/>	PEDIATRIC PATIENTS	Cefazolin	_____ mg/kg up to _____ mg		OR			
<input type="checkbox"/>	OTHER							

Additional Day of Surgery Orders

Physician Signature _____

Date _____

Time _____



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 _____

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 member, 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)297-6435, (970)297-6454 or (970)297-6449. Thank you!