HSC Harmony
SURGERY CENTER

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 Registration tab at the top of the page and print and fill out the Patient Registration Forms. *If you do not have printer or 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. A ride service is not a viable option as they will not take responsibility for your care at 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!**

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 – **<u>Cigna's</u>** 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

☐ 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
☐	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

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** ______________

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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: ______________________________

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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 ____________

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 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!