Harmony
SURGERY CENTER

PRE-OPERATIVE INSTRUCTIONS FOR SURGERY AT HARMONY SURGERY CENTER

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

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 oxygen or a CPAP machine at home, please bring it with you if staying overnight.
- Please bring all medical devices (compression hose, bra, binder, etc.) with you on the day of surgery.
- Notify your surgeon if you develop symptoms of cold, fever or other illness, as it may be necessary to postpone your procedure.
- 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.
- Please bring a book or something to keep you busy. You will have time waiting while in the facility.
- 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!**

NURSES NOTES:_____

_____

_____

_____

Harmony SURGERY CENTER

Scheduling Worksheet

Physician's Office Information

Physician Name: _____ *Scheduler Name & 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

Needs Interpreter?: ☐ Yes ☐ No **Language?:**_____

Patient's Name:_____ ***Sex:*** ☐M ☐F ***DOB***: _____ **Under 18** ☐Y ☐N

Primary Phone #: _____ **Email:** _____ **Last 4 Digits of SS#:** _____

Responsible Party Name (if pt < 18): _____ ***Relationship:*** _____

Address: _____ *Apt/Unit #*_____ *City:* _____ ***State:*** _____ ***Zip:*** _____

Does the Patient live in a Skilled Nursing Facility? ☐*Y* ☐*N* *If YES: Name of Facility:* _____
Address of Facility: _____

Insurance Information

☐Self-Pay ☐Cosmetic ☐Auto ☐Work Comp (if Auto or W/C, Date of Injury:_____)

Insurance Carrier: _____ *Insurance ID # or Claim #:* _____

Claim Office Address: _____ *Pre-Authorization #:* _____

Subscriber Name: _____ *Subscriber's DOB:* _____ *Relationship to patient:* _____

Secondary Insurance: _____ *Address:* _____ *ID#:* _____
*Please authorize all procedures & implants (call if you need HCPCS codes for implants)
*HSC is out of network for some Cigna plans, please verify in network status before scheduling
*Self-pay & Cosmetic cases require payment in full prior to procedure. Please schedule at least 10 days in advance.

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:
Please send scheduling information in a secure email to Jamie.Mullen@uchealth.org and Brittany.Noe@uchealth.org
Required information is in BOLD and ITALICS. If you have a copy of the insurance card, please include it.
Additional information required 72 hours prior to the case: patient consent, pre/post-op orders and the H&P. This can be sent to Justin at Justin.Green@uchealth.org

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Pre-Op Admit Orders

Patient Name:_____ Patient Weight:_____ Surgery Date:_____

Physician:_____ DX or Procedure:_____

Allergies

☐ NKDA

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.

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

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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: _____

_____

_____

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: Bleeding; Infection; Persistent Incontinence; Urinary Retention with need for catheter; Irritation, urgency or frequency; Reaction to sling material (inflammation, infection or allergic); Erosion of sling material into urethra; Discomfort from pulling of sutures; Discomfort with sexual intercourse; Thigh Pain; Damage to adjacent structures (bladder, ureter(s), rectum, etc.); blood vessels or nerves; Need for further treatment____

_____

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_____

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2127 East Harmony Road Suite 200 Fort Collins CO 80528
970.297.6300 www.harmonysc.com

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 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 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!