Jacqueline E. Jones, MD

1175 Park Avenue, Suite 1-A
New York, New York, 10128
(212) 996-2559

Dear Parent,

Your child has been scheduled for surgery at New York Presbyterian Hospital / Weill Cornell Medical Center on ______________________.

This packet contains information regarding your child's upcoming procedure with Dr. Jones.

✓ Information for Patients to Keep & Reference: Pages 1-2
- Information Regarding the Packet
- Surgery Instructions

✓ Patient to Complete & Return to Office: Pages 3-9
- Estimated Fee Agreement & Cancellation Policy
- Preoperative Procedure Questionnaire
- Surgical Consent Form

✓ Pediatrician to Complete & Return to Office: Pages 10-12
- History & Physical (Medical Clearance)
  _____CBC (Complete Blood Count)

PLEASE NOTE:
The medical clearance (H&P), blood work, patient questionnaire & consent forms must be received:

NO LATER THAN______________________.
Should a delay occur, we might have to reschedule your child's procedure.

Please fax all documents to Maureen:
212-981-9832

Please contact the Anesthesia Department at 646-962-4645 if you have questions about your insurance coverage for anesthesia.

We are committed to making the coordination of your surgery as easy and worry free as possible. If you have any questions at anytime, please do not hesitate to call or e-mail.
Sincerely,

Maureen Barrera
Surgical Coordinator
212-996-2559 x 5
MBarrera@ParkAvenueENT.com

Instructions Prior to Surgery

Jacqueline Jones, MD

I know that it can be very stressful preparing for surgery. The following instructions may help. After reading them carefully, please let me know if there is anything that you do not understand about the operation.

MEDICATION & VITAMINS OR SUPPLEMENTS

Two weeks before the surgery, stop using aspirin, Advil, Motrin, ibuprofen, vitamin E, vitamins, supplements, herbs or any similar drug that can cause bleeding problems. **Do not start using such drugs again until two weeks after the operation.** Use only Tylenol or Tylenol with codeine for pain. If you or your child takes any medicine on a regular basis for health reasons, let me know so we can decide whether or not it should be continued.

PREOPERATIVE TESTS

Before most operations I do require a blood test called a CBC, complete blood count. This test should be completed at least 5 days before surgery and certain operations might require a CT scan or other tests, but I will discuss this with you if necessary.

MEDICAL CLEARANCE

Your child's pediatrician must provide a complete written history and physical examination for the anesthesiologist. A special form is included in the packet and must be completed and received by my office at least 5 days (but not more than one month) before the surgery. However, it is best to bring a copy with you on the day of surgery to ensure that the operation will not be delayed.

SICKNESS

It is very common for children's surgery to be cancelled due to a cold or other infection, especially in the winter. This is mainly because the risk of anesthesia goes up if a patient has a respiratory infection. The anesthesiologist makes the final decision on the morning of surgery. While operations are not cancelled for minor symptoms, if your child is clearly sick with fever and/or a cough during the week before surgery, please check with me about rescheduling.

TIME OF SURGERY

The hospital is continually adding and removing cases to a busy schedule, and therefore does not assign starting times until each afternoon for the following day. The time will be given to you by the hospital. Please call the hospital between 2-6 PM the day before the surgery at 212-746-5111.

Please realize that the length of an operation can vary due to unforeseen circumstances, and a procedure may take longer than anticipated. You should understand that each patient has to be given our full attention for safety's sake, even if it means delaying the cases that follow. Therefore, the starting time that you are given is an estimate, and the later in the day you are scheduled, the more likely there is to be some degree of delay.

EATING AND DRINKING

Children should be watched carefully before surgery, since they may try to eat or drink, which will delay or cancel their operation. This is because it is dangerous to have anything in the stomach when anesthesia is given. **CLEAR liquids**, such as water, clear jello or apple juice (not cider), or Gatorade, are OK up to three hours before the time of surgery. **Everything else (including food and milk) must not be taken for eight hours prior to the operation**.

REGISTRATION

Please arrive at the hospital admissions desk at least 1 hour prior to your surgery time. The ambulatory surgery center at New York Hospital is located at 525 East 68th Street, between York Avenue and the FDR in the Starr Building on the 9th floor. Their phone number is 212-746-5111.

Jacqueline Jones, MD
(212) 996-2559
www.ParkAvenueENT.com

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1175 Park Avenue, Suite 1-A
New York, New York, 10128
(212) 996-2559

Estimated Surgical Fee Agreement & Cancellation Policy

Patient Name:____D.O.B.:_______________

Surgical Date:____________________ Surgeon: Jacqueline E. Jones, MD

The following is a pre-operative estimate of surgical charges for Dr. Jacqueline E. Jones, based on the procedure planned and outlined below. Findings during surgery may necessitate different and/or additional procedures by Dr. Jones. Such changes may alter the fees which you are being quoted. If so, a Final Fee agreement will be prepared for you after the surgery by our billing department.

As with any hospital based surgery, you can expect a bill and/or statement from the hospital and Anesthesiologist for their services.

______Dr. Jones participates with your insurance: therefore we will pre-certify the procedure(s) below and bill your carrier. As with all insurances, most plans include co-payments, deductibles and other expenses which must be paid by the patient. The responsible party will be responsible for the balance of these charges once the insurance company has paid their share. However, if your insurance is cancelled or is not in effect on the day of surgery and you neglect to inform us, you will be responsible for the full surgical fee.

______Either you have no insurance coverage for these services or Dr. Jones does not participate with your insurance plan. Therefore payment in full is expected on the day of surgery. You may leave a credit card number or a check with the billing department that will be processed following surgery. Upon processing the payment we will forward a receipt. As a courtesy, we will bill your insurance carrier directly on your behalf. All insurance reimbursements will be sent directly to the subscriber from the insurance company.

Cancellation Policy

We reserve a specific length of time for your procedure and would greatly appreciate that any cancellations or rescheduling be done at least 5 days in advance of your procedure. If we do not receive notice that the procedure needs to be cancelled or rescheduled in advance of 5 days, we will apply a cancellation fee, in the amount of $500, to your account. We understand that unexpected and inevitable events can and will occur and ask you to inform our office as soon as possible in the event of such.

We will waive the fee if your physician or pediatrician requests a cancellation due to medical reasons.

We appreciate your cooperation and understanding regarding our policy. Should you have any questions or concerns, please do not hesitate to contact our office at 212-996-2559 x 5.

Planned Procedures(s):

CPT Code	Procedure	Fee
	Total Estimated Fee	

Acknowledgement of Responsibility

By signing this document I accept the estimated surgical fees and cancellation policy and acknowledge that the total fee may change as a result of the clinical findings during surgery, and I assume full responsibility for final payment of all surgical charges and/or cancellation fee.

______________________________ ______________________________

Patient/Responsible Party Signature Date Responsibility Party Name (Print)

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION (PEDIATRIC PATIENTS NEWBORN - 18 YEARS)

Date: ______/______/____________ Time: ____________ AM/PM

Name: ______________________ Nickname: ______________________

Age: ________ Sex: ☐ Male ☐ Female Date of Birth: ______/______/____________

Legal Guardian: ______________________ Relationship: ______________________

Mother's Full Name: ______________________ Father's Full Name: ______________________

Home Phone#: (_____)______________ Work Phone #: (___)________ Cell Phone #: (___)________

Language(s) Spoken: ______________________ Translator: ______________________

Religion: ______________________ Any special religious needs: ______________________

Pediatrician: ______________________ Pediatrician Phone #: (_____)______________

Birth weight: __________ kg Current weight: __________ kg

Does your child have any allergies? ☐ NO ☐ YES ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER ______________

ALLERGY	REACTION

Please √ the following that apply:

Does your child have:

Hearing Aid.......................... ☐ No ☐ Yes
Eye Glasses....................... ☐ No ☐ Yes
Contacts............................ ☐ No ☐ Yes
Loose Teeth/ Chipped Teeth..... ☐ No ☐ Yes
Crutches............................ ☐ No ☐ Yes
Wheelchair.......................... ☐ No ☐ Yes
Gastric Tube.......................... ☐ No ☐ Yes
Tracheostomy........................ ☐ No ☐ Yes
Oxygen/ oximeter..................... ☐ No ☐ Yes
Other.................................. ☐ No ☐ Yes

Does your child need help with activities of daily living? ☐ No ☐ Yes

Walking.. ☐ No ☐ Yes
Dressing.. ☐ No ☐ Yes
Eating... ☐ No ☐ Yes
Transfer.. ☐ No ☐ Yes
Moving from Bed to Chair............................ ☐ No ☐ Yes
Bedridden... ☐ No ☐ Yes

How do you transport your child?
☐ Stroller ☐ Wheelchair ☐ Ambulatory ☐ Carried

PLEASE LIST ALL MEDICATION (INCLUDE ALL OVER THE COUNTER/ EYE DROPS/ HERBS) THAT YOUR CHILD IS CURRENTLY TAKING.

Is your child on aspirin? ☐ No ☐ Yes

Is your child taking any anticoagulation (Warfarin/ enoxaparin sodium/ heparin)? ☐ No ☐ Yes

Medication	Dose	How Often?	Last Given	Medication	Dose	How Often?	Last Given

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PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PAST MEDICAL HISTORY (include any chronic illnesses) / HOSPITALIZATIONS

___

What previous anesthesia has your child had?
☐ None
☐ General ☐ Regional ☐ Spinal
☐ Epidural ☐ Local

LIST PRIOR SURGERY/ PROCEDURES COMPLICATIONS (if any)

___

Please list any complications with anesthesia ___

Any family problems with anesthesia? ___

Was your child ever:
Treated in an intensive care unit? ☐ No ☐ Yes If yes, when & why? ___ where? ___
Seen in an Emergency Room in the last 3 months? ☐ No ☐ Yes If yes, when & why? ___ where? ___

SOCIAL INFORMATION:
Who does patient live with? ___
Are parents: ☐ married ☐ divorced ☐ separated Do parents live together? ☐ No ☐ Yes
If parents are divorced/ separated, is other parent involved? ☐ No ☐ Yes
What type of home do you live in? ☐ Apartment ☐ House Are there any stairs? ☐ No ☐ Yes How many? ___
Are there any pets in the home? ☐ No ☐ Yes If yes, what type? ___
Is there any Home Care Agency involved with your child? ☐ No ☐ Yes If yes, name of agency: ___
Contact Person: ___ Phone Number: (___) ___ Fax Number (if known): ___
Does your child attend any special programs (i.e. Down's, Early Intervention)? ☐ No ☐ Yes If yes, name of program: ___
What grade is your child in? ___ Name of School: ___ School Phone Number: (___) ___
Guidance Counselor: ___ Phone Number: (___) ___

NUTRITION:
Patient's usual diet: ___
Formula (type): ___ Amount per feeding: ___ How many feedings per day? ___ Length of feeding time? ___
☐ Breast ☐ Bottle ☐ Cup ☐ Baby Food ☐ Table Food
Appetite: ☐ Good ☐ Fair ☐ Poor
Does your child have difficulty swallowing/ sucking? ☐ No ☐ Yes
Has your child eaten less than half of their usual meal/ snack in the last 3 days? ☐ No ☐ Yes
Has your child experienced any unexplained weight loss? ☐ No ☐ Yes
Have you been told that your child is growing slower than expected? ☐ No ☐ Yes
Does your child have any wounds that have not healed? ☐ No ☐ Yes

*If yes to any of above the nurse will notify physician to determine need for further assessment.
MD notified: ___
Date: ___/___/___ Time: ___ AM/PM

Does your child:
use a pacifier? ☐ No ☐ Yes, specify ___
have a security object (i.e. blanket)? ☐ No ☐ Yes, specify ___
have any special bedtime/ nap needs? ☐ No ☐ Yes, specify ___
have a favorite activity/ toy? ☐ No ☐ Yes, specify ___
participate in sports/ hobbies? ☐ No ☐ Yes, specify ___

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PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

BIRTH HISTORY (complete only if child less than 6 years of age):

Hospital where child was born: ____________________ Number weeks gestation: ________

Complications during pregnancy/ delivery? ____________ ☐ Vaginal ☐ C- Section (reason for C-section) ________

Did your child at birth:

Have a period of breath holding?	☐ No	☐ Yes	Have a blood transfusion?	☐ No	☐ Yes
Have a breathing tube?	☐ No	☐ Yes	Appear blue ("blue baby")?	☐ No	☐ Yes
Have trouble breathing through the nose?	☐ No	☐ Yes	Have any feeding problems?	☐ No	☐ Yes
Appear yellow (jaundice)?	☐ No	☐ Yes	Other (specify): ________		

DEVELOPMENTAL DATA (complete based on your child's current age):

0 -6 Months	No	Yes	7 -15 Months	No	Yes	16 -24 Months	No	Yes
Head Control			Sits Alone			Obeys single step commands		
Visually follows objects			Crawls			Vocabulary of 10 words		
Lifts head when in prone position			Babbles/ utters sounds			Climbs stairs		
Smiles			Waves good- bye			Knows simple body parts		
Reaches			Pulls to standing position			Uses utensils		
Coos						Scribbles		
Looks at own hands								
Turns to parent's voice								
24 Months - 3 Years	**No**	**Yes**	**3 -5 Years**	**No**	**Yes**	**Special Concerns**	**No**	**Yes**
Helps get self dressed			Dresses self			Do you have any special concerns about your child's development? If yes, explain		
Able to wash and dry own hands			Prepares own cereal					
Able to draw in a straight line			Able to copy a circle					
Combines words			Know to count to 10					
Jumps up vertically			Speaks in full sentences					
Throws ball			Hops on one foot					
Words understandable to strangers								

HEART:

Does your child have:

Heart disease?	☐ No	☐ Yes	If yes, please explain ________
Heart murmur?	☐ No	☐ Yes	If yes, please explain ________
Chest pain?	☐ No	☐ Yes	What usually causes the pain? ________ How often? ________
Mitral valve prolapse?	☐ No	☐ Yes	If yes, please explain ________
Irregular heartbeat?	☐ No	☐ Yes	If yes, please explain ________
Rheumatic fever?	☐ No	☐ Yes	If yes, please explain ________
A pacemaker?	☐ No	☐ Yes	If yes, please explain ________
High blood pressure?	☐ No	☐ Yes	If yes, please explain ________
High cholesterol/ lipids?	☐ No	☐ Yes	If yes, please explain ________

Have you ever been told your child needs to take antibiotics prior to a procedure/ dental work? ☐ No ☐ Yes

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PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

BREATHING:
Does your child:

Get short of breath?	☐ No	☐ Yes	
Have asthma or wheezing?	☐ No	☐ Yes	
Have BPD (bronchopulmonary dysplasia)?	☐ No	☐ Yes	
Have a productive cough?	☐ No	☐ Yes	If yes, for how long? ______
Have a history of pneumonia?	☐ No	☐ Yes	If yes, when? ______
Have a history of RSV or bronchiolitis?	☐ No	☐ Yes	
Does your child snore?	☐ No	☐ Yes	
Has your child had a recent cough or cold in the past 2 weeks?	☐ No	☐ Yes	If yes, MD notified: ______
			Date: ____/____/______
			Time: ______ AM/PM

DIGESTION/ ELIMINATION:
Does your child have:

Chronic stomach ache/pain	☐ No	☐ Yes	
Reflux (GERD)?	☐ No	☐ Yes	
Colitis?	☐ No	☐ Yes	
Diarrhea frequently?	☐ No	☐ Yes	
Constipation frequently?	☐ No	☐ Yes	
Urinary tract infections/kidney problems?	☐ No	☐ Yes	
A stoma?	☐ No	☐ Yes	
An umbilical, inguinal, or hiatal hernia?	☐ No	☐ Yes	
A diaper rash?	☐ No	☐ Yes	If yes, how do you treat it? ______
Nausea?	☐ No	☐ Yes	If yes, for how many days? ______
Is your child toilet trained?	☐ No	☐ Yes	If yes, term used: ______
Last bowel movement ______			

MUSCULOSKELETAL/ SKIN:
Does your child:

Move all extremities without difficulty?	☐ No	☐ Yes
Have chronic muscle/ joint pain?	☐ No	☐ Yes
Have any weakness in arms or legs?	☐ No	☐ Yes
Have any areas of skin redness/ rash or skin breakdown?	☐ No	☐ Yes
Have any bone fractures?	☐ No	☐ Yes
Have scoliosis?	☐ No	☐ Yes

ENDOCRINE DISEASE:
Does your child have:

Diabetes?	☐ No	☐ Yes	
Hypoglycemic (low blood sugar)?	☐ No	☐ Yes	
Metabolic disease?	☐ No	☐ Yes	If yes, specify: ______
Thyroid disease?	☐ No	☐ Yes	

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PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

NEUROLOGIC:
Has your child had:

Stroke?	☐ No	☐ Yes	Headaches?	☐ No	☐ Yes
Seizures?	☐ No	☐ Yes	Fainting spells?	☐ No	☐ Yes
Learning disabilities?	☐ No	☐ Yes	Speech difficulties?	☐ No	☐ Yes
Dizziness?	☐ No	☐ Yes	Hearing loss?	☐ No	☐ Yes
Difficulty seeing?	☐ No	☐ Yes			

Has your child ever been diagnosed with a genetic or chromosomal syndrome? ☐ No ☐ Yes If yes, specify___________

CANCER:
Has your child:

Been diagnosed with cancer? ☐ No ☐ Yes If yes, specify___________

Received radiation/ chemotherapy? ☐ No ☐ Yes If yes, last treatment___________

Placed on isolation / special precautions? ☐ No ☐ Yes If yes, specify___________

COMMUNICABLE DISEASES:
Has your child been exposed within the last 3 weeks to:

Chicken pox?	☐ No	☐ Yes	Mumps?	☐ No	☐ Yes
Measles?	☐ No	☐ Yes	Hepatitis?	☐ No	☐ Yes
Tuberculosis?	☐ No	☐ Yes			

Are your child's immunizations up to date? ☐ No ☐ Yes If no, explain ___________

BLOOD/ TRANSFUSIONS:
Does your child have?

Bleeding problems?	☐ No	☐ Yes	Bruise easily?	☐ No	☐ Yes
Sickle cell trait/ disease?	☐ No	☐ Yes	Anemia?	☐ No	☐ Yes

Do you refuse blood transfusions? ☐ No ☐ Yes
Has your child ever had a transfusion reaction? ☐ No ☐ Yes

PARENT/ GUARDIAN SIGNATURE: ___________

DATE: ____/____/______ Time: ________ AM/PM

TO BE COMPLETED BY R.N. (If interviewed prior to day of surgery)

METHOD OF INTERVIEW: ☐ Face to Face ☐ Telephone
INFORMANT: ☐ Patient ☐ Parent/ Legal Guardian

DIAGNOSIS: ___________

PROCEDURE: ___________

DATE: ____/____/______ **TIME:** ________ AM/PM

T ______ °C **P** ______ **R** ______ **BP** ______ **Ht** ______ in/cm **Wt** ______ kg

Form Reviewed by ___________ **RN** **DATE:** ____/____/______
Signature

TIME: ________ AM/PM

___________ **ID Code:** ___________
Print Name

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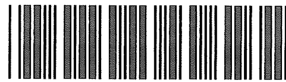

45350

CONSENT FOR SURGICAL / INVASIVE PROCEDURE

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

I hereby give my consent and authorize Dr. ______________________ and NewYork-Presbyterian Hospital ("Hospital") and its staff to perform the following surgical/invasive procedure ("procedure") upon ______________ (name of patient). **(Describe procedure, and if applicable the specific implant/implant system to be placed or device to be removed). (NO ACRONYMS OR ABBREVIATIONS EXCEPT FOR SPINAL LEVELS):**

____

____

Procedure Site - Check applicable box(es)

☐ Right-side ☐ Left-side ☐ Bilateral ☐ Spinal Level(s) ______________ ☐ Digit(s) ______________

______________________ **has explained to me, in a way that I understand, the following:**
(Name of Physician/Appropriately Credentialed Practitioner)

1. The nature, purpose and the reasonably foreseeable risks and benefits of the procedure; the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives;
2. That the practice of medicine is not an exact science and the procedure may not result in the intended benefits;
3. That there are risks associated generally with anesthesia, surgery, use of medication, medical procedures and treatments not ordinarily anticipated which can cause adverse consequences to my life or health; and
4. That other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the surgery.

NOTE: If the patient is under eighteen (18) years, the permission of the patient's parent or legal guardian must be obtained, unless the patient is married or the parent of a child.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above. I understand that certain tubes, catheters, and lines may be placed during the procedure and I give my consent for replacement of those tubes, catheters, and lines as indicated. I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

______________ ______________ ______________ ____/____/____ Time:______ AM PM
(Patient/Health Care Agent/Guardian/Family Signature) (Printed Name) (Relationship to Patient) (Date)

By initialing here ☐ I consent to the use of film or recording of the procedure for internal educational and performance improvement purposes.

By initialing here ☐ I consent to the presence of a vendor during the procedure.

______________ ______________ ____/____/____ Time:______ AM PM
(Witness' Signature) (Printed Name) (Date)

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

______________________ M.D. ______________ ____/____/____ Time:______ AM PM
(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation) M.D. ID Code (Date)

Day of Surgery/Correct procedure site/side verification: (to be completed on day of surgery)

Date: ____/____/____ Time: __________ AM/PM

☐ Right-side ☐ Left-side ☐ Bilateral ☐ Spinal Level (s) ______________ ☐ Digit(s) ______________

Signatures

Patient/Health Care Agent/Guardian/Family Signature: ______________________

RN: ______________ RN: (Print Name)______________

Surgeon/Appropriately Credentialed Practitioner: ______________________ M.D.

Surgeon/Appropriately Credentialed Practitioner (Print Name): ______________ ID Code: __________

TRANSFUSION CONSENT ON REVERSE SIDE - COMPLETE IF INDICATED

45350 (1/11)

If this consent is altered or illegible it must be re-done and re-signed by all parties

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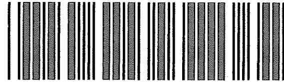
50173

☐ SDS
☐ AS

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL DAY OF SURGERY ORDERS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: ____/____/____ **Time:** ________ **AM/PM**

SUBMIT THIS DOCUMENTATION AND ALL TEST RESULTS TO THE PRESURGICAL DOCUMENTATION CENTER NO LATER THAN 2 DAYS PRIOR TO THE DATE OF SURGERY

PATIENT NAME:	ADMISSION DIAGNOSIS: (1)
HISTORY NUMBER: (UNCONFIRMED) AGE: DOB:	SECONDARY DIAGNOSIS: (2)
FATHER'S FULL NAME:	PROCEDURE/OPERATION:
REFERRING PHYSICIAN NAME:	PROCEDURE DATE: ____/____/____ CONFIRMATION #:
GOING TO PAT ☐YES ☐NO PREADMISSION TESTING DATE: ____/____/____ PAT AT NYPH? ☐YES ☐NO Where ______	PRINT SURGEON NAME/ID CODE:

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS (HPI):
Specific Surgical in PI: Narrative HPI

HISTORY:

Past Surgical History:

Surgery	Date
	/ /
	/ /
	/ /
	/ /

Past Medical History:

Condition	Date
	/ /
	/ /
	/ /
	/ /

Medications: List of Medications (including over -the-counter medications): (Complete Medication Reconciliation form - 51187)

Medications	Dosage	Frequency

Family History: ☐ Heart Attack ☐ Cancer ☐ Colon Problems ☐ Other ____________ ☐ None

Do you have allergies? ☐ Yes ☐ No ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER ____________

ALLERGEN	REACTION

50173 (1/11)

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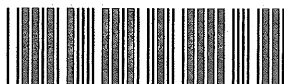

50173

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

REVIEW OF SYSTEMS:

	Normal	Abnormal	Describe Abnormal findings
Constitution	☐	☐	☐ Fever ☐ Weight loss ☐ Other ______
Cardiovascular	☐	☐	☐ Heart attack ☐ Chest pain ☐ Mitral valve prolapse ☐ Hypertension ☐ Claudication ☐ Other ______
Respiratory	☐	☐	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Cough ☐ SOB ☐ Other ___
Gastrointestinal	☐	☐	☐ GERD ☐ Peptic Ulcer disease ☐ Diverticulitis ☐ Irritable bowel ☐ Hepatitis ☐ Cirrhosis ☐ Hypercholesteremia ☐ Gall Bladder disease ☐ Other ______
Genitourinary	☐	☐	☐ Renal Failure ☐ Other ______
Musculoskeletal	☐	☐	☐ Rheumatoid arthritis ☐ Other ______
Neurologic	☐	☐	☐ Stroke ☐ Other ______
Psychiatric	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Other ______
Endocrine/Metabolic	☐	☐	☐ Diabetes ☐ Lupus ☐ Thyroid disease ☐ Other ______
Hematologic/Lymphatic	☐	☐	☐ Anemia ☐ Other ______
Substance Abuse	☐ No	☐ Yes	substance ______ last used : ___/___/___
Smoking	☐ No	☐ Yes	when quit : ___/___/___ ppd: ______
Cancer	☐ No	☐ Yes	______
Other	☐	☐	______

PHYSICAL EXAM: (check all that apply)

CONSTITUTIONAL:

VS: Temp ______ °C Pulse ______ Respiration ______ BP ______ Height ______(cm) Weight ______(kg)

General Appearance ☐ Normal ☐ Malnourished ☐ Overweight ☐ Obese ☐ Morbidly obese

EYES

Inspection of conjunctiva, lids: ☐ Normal ☐ Icteric conjunctiva ☐ periorbital edema ☐ abnormal sclerae ☐ Other ______

Examination of pupils/iris: ☐ PERRLA ☐ Other: ______

NECK

Overall appearance: ☐ Normal **Masses:** ☐ None ☐ Lymph nodes ______ ☐ JVD ☐ Other: ______

Thyroid: ☐ Normal ☐ Other: ______

RESPIRATORY

Effort: ☐ Normal ☐ Tachypneic ☐ Use of accessory muscles ☐ Other: ______

Lungs (Auscultation): ☐ Normal ☐ Other ______

CARDIOVASCULAR

Auscultation of Heart: ☐ Normal ☐ Murmur ☐ Other ______

Examination of Extremities: ☐ Normal ☐ Venous insufficiency ☐ Varicose veins ☐ Edema ☐ Other ______

GASTROINTESTINAL

Examination of Abdomen: ☐ Normal ☐ Masses ______ ☐ Tenderness ______

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL DAY OF SURGERY ORDERS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

MUSCULOSKELETAL:
Examination of Gait and Station: ☐ Normal ☐ Abnormal ____________
Assessment of Strength and Tone: ☐ Normal ☐ Atrophy __________ Tremor __________ ☐ Other __________

SKIN
Inspection: ☐ Normal ☐ Erythema ☐ Stasis dermatitis ☐ Jaundice ☐ Ulcer __________
☐ Other ____________________

Palpation: ☐ Normal ☐ Induration ☐ subq nodules ☐ Other ____________________

NEUROLOGICAL/PSYCHIATRIC
Orientation: ☐ Normal ☐ Other ____________________
Mood: ☐ Normal ☐ Other ____________________

DIAGNOSIS:

PLAN FOR SURGERY:

INFECTION PRIOR TO ANESTHESIA/PRINCIPAL PROCEDURE/SURGERY START TIME

☐ Yes, Preoperative Infection exists

☐ Yes, Suspected / Possible Preoperative Infection exists

☐ No

JUSTIFICATION / REASON FOR VANCOMYCIN USE: (check all that apply)

☐ Beta-lactam (penicillin or cephalosporin) allergy

☐ High-risk due to acute inpatient hospitalization within the last year

☐ High-risk due to nursing home or extended care facility setting within the last year, prior to admission

☐ Inpatient stay more than 24 hours prior to the principal procedure

☐ Transferred from another inpatient hospitalization after a 3-day stay

☐ MRSA colonization or infection

☐ Chronic wound care or dialysis

☐ Increase MRSA rate, either facility-wide or operation-specific

☐ Undergoing valve surgery

Signature: ______________________ MD/PA/NP Date: ____/____/______ Time:________AM/PM

Print Name:______________________ ID CODE # ______________

Reviewed by Attending Surgeon: ______________________ MD Date: ____/____/______ Time:________AM/PM

Print Name:______________________ ID CODE # ______________