Jacqueline E. Jones, MD

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

Dear Patient,

You are 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 1-3
  - Information Regarding the Packet
  - Surgery Instructions

- ✓ Patient to Complete & Return to Office: Pages 4-
  - Estimated Fee Agreement & Cancellation Policy
  - Preoperative Procedure Questionnaire
  - Surgical Consent Form

- ✓ Primary Care Physician or Internist to Complete & Return to Office: Pages
  - History & Physical (Medical Clearance)
    _____CBC (Complete Blood Count)
    _____PT/PTT
    _____EKG

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 procedure.

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

Please contact the Anesthesia Department at 212-746-2793 or 646-962-4645 if you have questions about insurance and billing 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.

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

Two weeks before the surgery, stop using aspirin, Advil, Motrin, ibuprofen, vitamin E, vitamins/supplements 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 take 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 primary care physician 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 4 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 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 you are 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

Jacqueline E. Jones, MD

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

Ambulatory Surgical Instructions

New York Presbyterian Hospital Weill Cornell Medical Center

1. The patient will require a medical clearance, blood work and in some cases an EKG from their primary care physician, no less then 1 week and no more then 2 weeks from the date of the surgery. All the forms are included in the packet.

2. Do Not Take: Asprin , Aspirin like products, Advil, Aleve, Motrin, Nuprin, Ibuprofen, or vitamin E or vitamin E containing products two weeks prior to and two weeks after surgery. These products can cause bleeding and we want to avoid minimal blood loss during procedures.

3. Solid foods are not allowed after midnight the night prior to the surgery. Clear liquids such as water, plain tea, clear broth, jell-o and ginger-ale are permitted up to three hours prior to the surgery.

4. The day prior to the surgery, the patient should receive a phone call from the hospital providing the time and location of the procedure. Should you not receive a call, please call the Cantor Ambulatory Center at 212-746-5111 between 4 PM and 7 PM.

5. The day of surgery, the patient will report to 520 E 70th Street (between York & FDR Drive). The Cantor Ambulatory Center is located on the 9th Floor, room L919.

6. Contact the office immediately if you develop a fever within a few days of surgery.

7. Please call our office to schedule your post operative appointment.

8. If your insurance has changed, please call our office immediately to update your records. Most insurance carriers require pre authorization for surgery and can take up to 4 weeks to complete.

Jacqueline E. Jones, MD

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)

PATIENT TO COMPLETE
If Paper Fax: 212-891-0832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

Patient Name:

DOB:

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

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: _____

Fluent in English: ☐ Yes ☐ No Language Spoken: _____ Translator needed: ☐ Yes ☐ No

Age: _____ Sex: _____ Date of Birth: _____/_____/_____

Surgeon Name:. Jacqueline E Jones, MD Expected Date of Surgery _____/_____/_____

Primary Care Physician: _____

Primary Care Physician's Phone No. (_____) _____

Cardiologists Name _____ Phone No.: (_____) _____

Expected Procedure: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Telephone Number to be Reached Prior to Surgery: _____

Best time to call: ☐ Afternoon ☐ Evening May we leave a message? ☐ Yes ☐ No

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

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

What previous Anesthesia have you had?

☐ General ☐ Regional ☐ Spinal ☐ Epidural ☐ Local ☐ None ☐ Unsure

Please list any complications/problems experienced with anesthesia.

_____

_____

_____

Please list prior Hospitalizations including Emergency Department visits

_____

_____

_____

PATIENT TO COMPLETE
& FAX TO: 212.981-9832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Patient Name:

DOB:

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

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

	PATIENT ONLY		CLINICIAN USE ONLY	
Heart: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
1) Atrial fibrillation or irregular heartbeat?			EKG	*
2) High blood pressure or Mitral Valve Prolapse?			EKG	
3) A heart attack, angina, or chest pain?			CBC, EKG	*
4) A heart murmur, heart failure or heart surgery?			CBC, EKG	*
5) High cholesterol?				
6) Chest pain or shortness of breath when climbing a flight of stairs?			EKG	*
7) A catheterization of your heart? If so, ….. Date ___/___/___ Where _____			CBC, EKG	*
8) A heart stress test? If so, ….. Date ___/___/___ Where _____			CBC, EKG	
Do you:				
9) Take antibiotics prior to a surgical procedure or dental work?				
10) Do you have a pacemaker or implantable defibrillator (AICD)? If yes, manufacturer: (check one) ☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Biotronik ☐ Other Date ___/___/___ Where _____ ***Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.***			EKG **If yes, contact EP specialist**	
11) Are you 60 years old or older?			EKG	
Breathing: Do you have or ever had the following:				
12) Shortness of breath with exertion or swollen ankles?			CBC, EKG	*
13) A need for more than one pillow or wake up at night short of breath?			CBC, EKG	
14) Tuberculosis (TB)?			CXR	
15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?			CBC, CXR	
16) Smoked in the last year?				
17) Oxygen at home to help you breathe?			CBC, CXR	*
18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?			EKG, CXR	*
19) Did you ever have an embolus or clot go to your lung?				
Obstructive Sleep Apnea (OSA):				
20) Do you have Obstructive Sleep Apnea (OSA)?			CBC, EKG, CXR	*
21) Do you frequently snore loudly, enough to be heard through closed doors?			CBC, EKG	
22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?			CBC, EKG	*
23) Do you have or are you being treated for high blood pressure?			EKG	
24) Do you use a BiPAP or C-PAP machine at home? If so, settings: _____			CBC, CXR	*

* Anesthesia Consult Recommended

CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

PATIENT TO COMPLETE
& FAX TO: 212-821-0832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

Patient Name:

DOB:

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

	PATIENT ONLY		CLINICIAN USE ONLY	
	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
Blood Disorders: Do you have or ever had the following:				
25) Anemia or low blood count?			CBC	
26) Bleeding ulcers or rectal bleeding?			CBC	
27) Sickle cell disease or trait?			CBC, CXR	
28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?				
Do you:				
29) Use warfarin (Coumadin) as a blood thinner?			PT/INR	*
30) Bruise easily and/or have a bleeding problem?			CBC, PT/INR/APTT	
Endocrine/Renal Disorders: Do you have or ever had the following:				
31) Diabetes?			BMP, EKG	
32) Adrenal or thyroid disease or tumor?			BMP	
33) Kidney disease, kidney failure or are you on dialysis?			BMP, EKG, CBC	
34) Severe hepatitis, jaundice, cirrhosis or liver failure?			LIV, PT, INR, APPT	
35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?			BMP, EKG	
Gastrointestinal: Do you have or ever had the following:				
36) Severe abdominal pain?				
37) Loss of appetite or unintentional weight loss in the past year?				
38) Acid reflux?				
Neurological/Musculo/Skeletal: Do you have or ever had the following:				
39) Stroke or seizures?			BMP, EKG, CBC	
40) Weakness in your arms or legs?				
41) Head, neck or back injuries?				
42) Chronic pain?				
43) "Pins and needles" or loss of sensation in your arms or legs?				
44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				
Obstetrics				
45) Are you or do you believe you might be pregnant?			BHCG	
Last menstrual cycle _____.				
46) Have you been pregnant in the last 3 months?			If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	
Cancer: Do you have or ever had the following:				
47) Cancer and/or received chemotherapy?			CBC	
48) Have you received radiation therapy?			CXR, EKG, CBC	
49) An axillary lymph node dissection (under arm): ☐ Yes ☐ No				
Which side: _____				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

PATIENT TO COMPLETE
& FAX TO: 212-981-9832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Patient Name:

DOB:

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

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

	PATIENT ONLY		CLINICIAN USE ONLY	
	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
Anesthesia Related Issues: Have you had:				
50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?				*
51) Surgery on your throat, vocal cords or lungs?				*
52) Any bad reactions to anesthesia in you or your relatives?				*
53) A history of Malignant Hyperthermia in you or any of your relatives?				*
54) Do you have trouble opening your mouth or bending your neck forward or backward?				*
55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?				*
You will see YOUR anesthesiologist on the day of surgery. In addition, 56) Do you want to see a screening Anesthesiologist before the day of Surgery?				*
Communicable Disease: Do you have or ever had the following:				
57) ☐ HERPES ☐ AIDS ☐ HIV				
58) Contact within the last month with anyone suspected of having SARS?				
59) Have you traveled outside of the U.S. in the last month? If yes, where? _____				
Eyes: Do you have or had the following:				
60) Dry eyes?				
61) Glaucoma or cataracts?				
Behavioral Health				
62) Have you suffered from anxiety, depression, or a psychiatric disorder?				
Blood Transfusion: Do you have or had the following:				
63) Blood transfusion in the last 3 months?			If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	
64) A reaction or allergy to a blood transfusion?				
65) Did you donate blood for this surgery?				
66) Did a family member donate blood?				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature _____ Date: ____/____/_____ Time: _____ AM/PM

If completed by the RN: _____ RN Date: ____/____/_____ Time: _____ AM/PM
Nurses Signature

PATIENT TO COMPLETE
MRN: [illegible]

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

45350

CONSENT FOR SURGICAL / INVASIVE PROCEDURE

Patient Name:

DOB:

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

I hereby give my consent and authorize Dr. Jacqueline E Jones 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) _____

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

_____ MD/NP/PA JOO36 ____/____/_____ Time: _____ AM PM
(Signature of Physician/Appropriately Credentialed Practitioner) Print Name/M.D. ID Code (Date)

Day of Surgery: Verification of correct procedure AND site/side: (to be completed on day of surgery by RESPONSIBLE provider performing the surgery or procedure)

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) _____

Physician/Appropriately Credentialed Practitioner: _____ MD/NP/PA

Physician/Appropriately Credentialed Practitioner (Print Name): _____ ID Code: _____

TRANSFUSION CONSENT ON REVERSE SIDE - COMPLETE IF INDICATED

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

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Patient Name:

DOB:

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

PERMISSION FOR BLOOD TRANSFUSION

I will accept Blood/Blood Products ☐ **Yes** ☐ **No**

Restrictions/Limitations _____

1. I authorize New York Presbyterian Hospital and its staff to administer to me, or the named patient, blood transfusion(s)[1] and/or factor concentrate infusion as indicated.

2. In connection with my consent to this procedure, my physician has provided me with information about, and discussed and explained to me the following:

   A. The nature, purpose, and reasonably foreseeable risks and benefits of the transfusion, the alternatives, including autologous and directed donation as well as not performing the transfusion, as well as the reasonably foreseeable risks and benefits of the alternatives.

   B. That a blood transfusion is not always successful and that no guarantee or assurance has been given to me or anyone concerning the results of transfusion, and that I may be subject to ill effects as a result of receiving blood and/or blood products.

   C. That this consent applies to all transfusions I receive during this hospitalization and if I am an outpatient to all transfusions during the course of this treatment.

3. I confirm that I have read (or have had read to me) the above consent and fully understand all information given to me. All my questions have been answered.

Patient/Health Care Agent/Guardian/Relative: _____ (Signature)

_____(Print Name)

Relationship if other than patient: _____ Date: ____/____/_____ Time: _____ AM/PM

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

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

Physician/Appropriately Credentialed Practitioner: _____ MD/NP/PA

Print Name/ID Code: _____ Date: ____/____/_____ Time: _____ AM/PM

***NOTE:** **The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of eighteen (18) or is otherwise unable to consent.**

* "Blood Transfusion" means the administration of red cell, white cell, platelet, cryoprecipitate and plasma products.

Internist to Complete & Fax to
212-981-9832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50173

☐ SDS
☐ AS

Patient Name:

DOB:

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

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL DAY OF SURGERY ORDERS

Date: _____/_____/_____

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: Jacqueline Jones, MD J0036

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 (5/07)

Internist to Complete & Fax to
212-981-9832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Patient Name:

DOB:

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 _____ Pulse _____ Respiration _____ BP _____ Height _____(inches/cm) Weight _____(lb/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 _____

Internist to Complete & Fax to
212-981-9832

NewYork-Presbyterian
The University Hospital of Columbia and Cornell


50173

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS

Patient Name:

DOB:

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

CARDIOVASCULAR

Auscultation of Heart: ☐ Normal ☐ Murmur ☐ Other _____

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

GASTROINTESTINAL

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

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: (IF SURGERY IS PLANNED SEE PERIOPERATIVE PROPHYLAXIS)

Signature _____ MD/PA/NP Date: _____/_____/_____

Print Name: _____ ID CODE # _____