Greenwich Village Ambulatory Surgery Center

Please fax results to:

914-725-6972
Jasmin

PHYSICIAN'S ORDER FORM FOR PRE-ADMISSION TESTING

Date of Surgery:
Patient's Name:
Surgeon's Name: **Benjamin B. Bedford, M.D.**

TEST RESULT SUBMISSION:

- **No tests required for healthy patients without medical problems.**
- The patient's name, testing date and date of birth must appear on every test document
- All laboratory tests must be performed by a CLIA (Clinical Laboratory Improvement Act) approved laboratory. Lab tests are good for 30 days prior to surgery.
- In the absence of recent medical problems, chest X-ray is valid for six months and ECG is valid for 3 months.

☐ No testing Ordered or Required

ICD 9 Codes
Must indicate reason/diagnosis for all testing
Please refer to the next page for a list of the ICD 9 codes.

Laboratory Tests	INDICATOR	ICD-9 CODES
☐ BMP (BUN, Na, K, Cl, Glu, Creat, Ca, CO2) ☒ CMP (Alb, TBIL, Ca, CO2, Creat, Glu, AlkP, TP, Na, SGOT,BUN,SGPT,Cl,K) ☐ Potassium level	Patient has been diagnosed with renal disease Patient is taking a diuretic drug that can cause hypokalemia or any other drug that can cause electrolyte abnormalities Patient is taking digoxin ESRD patients on dialysis	
☒ CBC		
☒ PT/PTT/NR	Patients whose surgery is likely to be performed under regional anesthesia and are taking or have recently taken anticoagulant drugs	
☒ Urinalysis		
☐ HCG Serum ☐ HCG Urine	If the patient is a woman of childbearing age	
☒ ECG Age is not a factor.	Patient has at least 1 risk factor (Ischemic heart disease, Renal disease, Cerebrovascular disease, Diabetes, Hx. Of heart failure)	
☐ Chest X - Ray Chest Xray is not required if patient's condition is stable	Patients who have chronic pulbmonary disease (emphysema, bronchitis, asthma), chronic congestive heart failure or who have experienced a recent exacerbation of symptoms deviating from a stable state	
☐ Sleep study	Patient with diagnosis of or symptoms suggestive of obstructive sleep apnea if appropriate for age, unless determined by Otolaryngologist, Neurologist or Pulmonologist	

Date: _____ Time: _____

M.D. Signature: _____ UPIN# _____

PHY-804 (9/09)

SM40

Northwell Health | Greenwich Village Ambulatory Surgery Center

Address: 200 W 13th St New York, NY 10011 | 4th Floor | Phone: (929) 292-3700

HISTORY AND PHYSICAL

Name: **D.O.B./Age:** **Today's Date:**

Reason for Visit:

SIGNIFICANT HISTORY:

Medical History: ☐ None

Surgical History: ☐ None

Transfusions: ☐ None

Allergies: NKDA ☐ None

LMP: ☐ N/A

Habits: ☐ None

Medications/Herbals (Doses & Frequency) ☐ None

Review of Systems

Physical Exam/Comments:

VITAL SIGNS:

HR:	**B/P:**	**Resp:**	**Temp:**
Height:		**Weight/BMI:**	
HEENT:		**Abdomen:**	
Chest:		**Pelvic:**	
Heart:		**Rectal:**	
Breasts:		**Extremities:**	
Lungs:		**Other:**	

Pertinent Labs/Testing/Imaging Studies:

Impression/Indications for Surgery:

Medication/Pre-Op Orders:

Physician's Signature: _____ Date: 2/22/2019 Time: 8:37:27 AM

TO BE COMPLETED BY SURGEON ON DAY OF SURGERY

☐ Refer to attached history and physical dated _____ performed by _____

IMMEDIATE PREOPERATIVE REASSESSMENT

I have reviewed the above evaluation, I have re-evaluated the patient immediately prior to the procedure, and I have found:

☐ No significant interval changes in his/her condition

☐ Significant change which I have documented in the Medical Record

This patient is cleared for surgery in a free-standing ambulatory surgery center.

Physician's Signature: _____ Date: _____ Time: _____

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200 WEST 13TH ST NEW YORK,NY 10011 | 4TH FLOOR | P: (929) 292-3700 | F: (646) 396-4094

Pre-Op Questionnaire

*Must be completed by patient in office and submitted with booking paperwork

Name: _____

DOB: _____ Height _____ Weight _____ BMI _____

Telephone Number: _____

Prefered Language: _____

Emergency Contact: _____

Relationship: _____ Number: _____

Last Mentral Period: _____

Primary Medical Doctor: (Name & number) _____

Cardiologist (if applicable): _____

Allergies: (including food, latex, dyes) _____

List all meds that you take regulary(Use attached sheet) : ☐ None

Do you take Aspirin/blood thinners? ☐ No ☐ Yes,

Name: _____ Last taken: _____

Do you smoke? ☐ No ☐ Yes, How mant packs per day? _____

How often do you drink? ☐ Seldom ☐ Socially ☐ Heavily

List all operations that you've had and year of surgery:

Have you been hospitalized for any medical conditions? ☐ No ☐ Yes, Explain

Have you had any problems with anesthesia in the past?

Describe: _____

Any anesthetic problems in your family: _____

	Yes	No
Do you have any loose teeth, dentures or caps?	☐	☐
Do you wear contanct lenses?	☐	☐
Past history of drug abuse?	☐	☐
Do you have high blood pressure?	☐	☐
Do you get chest pain (angina)?	☐	☐
Have you had a heart attack or congestive heart failure?	☐	☐
Do you get palpitations?	☐	☐
Have you ever had rheumatic fever	☐	☐
Do you have a heart murmur?	☐	☐
Do you have a pacemaker/AICD?	☐	☐

Place Patient Label Here

	Yes	No
Do you get short of breath if you do not sleep on 2 or more pillows?	☐	☐
Have you had a recent cough cold, fever, infection?	☐	☐
Do you have asthma, bronchitis, emphysema or history of pneumonia	☐	☐
Do you have stomach problems (ulcer or heartburn)?	☐	☐
Do you have a hiatal hernia?	☐	☐
Have you ever been treated for anemia?	☐	☐
Do you have sickle cell anemia or trait?	☐	☐
Do you bruise or bleed easily?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Have you ever had kidney failure, stones or infections?	☐	☐
Do you have thyroid disease?	☐	☐
Are you diabetic?	☐	☐
Do you have liver disease (cirrhosis or hepatitis)?	☐	☐
Do you have arthritis of your jaw, neck or back?	☐	☐
Do you have difficulty opening your mouth?	☐	☐
Any history of seizures?	☐	☐
Have you ever had a stroke or temporary blackout?	☐	☐
Have you had a significant weight loss in the last 6 months without dieting?	☐	☐
Do you have or have been diagnosed with Sleep Apnea?	☐	☐
If yes, do you use CPAP?	☐	☐
Do your calves get cramps when you walk a short distance?	☐	☐

If you answered yes to any question please explain below:

Escort (Adult > 18 yrs old) Name: Number:

Patient or Person completing form Date

Anesthesia Review(Signature) ☐approved ☐ not approved Date & time

Notes:

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Preoperative STOP BANG Questionnaire for Obstructive Sleep Apnea

This tool is to be completed during the preoperative interview to assess the potential for obstructive sleep apnea (OSA). Answers to these questions will assist anesthesia in identifying the risk and possible need for Pulmonary Clearance and/or Sleep Study prior to surgery.

Please check here if you have already been diagnosed with sleep apnea ☐

	Yes	No	
1.	☐	☐	**Snoring**: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
2.	☐	☐	**Tiredness/Fatigue**: Do you often feel tired, fatigued or sleepy during the daytime, even after a good night's sleep?
3.	☐	☐	**Observed Apnea**: Has anyone ever observed you stop breathing during your sleep?
4.	☐	☐	**Pressure**: Do you have or are you being treated for high blood pressure?
5.	☐	☐	**Body Max Index**: Is patients weight a BMI of 35 or higher?
6.	☐	☐	**Age**: Are you older than 50 years of age?
7.	☐	☐	**Neck Size**: Does your neck measure more than 15 ¾" for women and 17" for men?
8.	☐	☐	**Gender**: Are you a male?

Please check the Risk below:

☐ Low Risk of OSA:	Yes to 0-2 questions
☐ Intermediate Risk of OSA:	Yes to 3-4 questions
☐ High Risk of OSA:	Yes to 5-8 questions

Completed By: _____ Date: _____ Time: _____

Anesthesia Review

Anesthesiologist: _____ Date: _____ Time: _____

Department of Anesthesiology follow up recommendations:

☐ See Pulmonologist for Preoperative Clearance

☐ Advise patient to see Pulmonologist Post Op for follow up

☐ No action required

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Patient Name: _____ Date of Birth: _____

Medication Name	Dose(i.e.mgs.) Frequency	Reason Taking