

**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:**

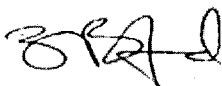
- **No tests required for healthy patients without medical problems.**
- The patient's name, testing date and date of birth must appear on every test document
- All laboratory tests must be performed by a CLIA (Clinical Laboratory Improvement Act) approved laboratory. Lab tests are good for 30 days prior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

**ICD 9 Codes**

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

No testing Ordered or Required

Laboratory Tests	INDICATOR	ICD-9 CODES
<input type="checkbox"/> BMP (BUN, Na, K, Cl, Glu, Creat, Ca, CO2) <input checked="" type="checkbox"/> CMP (Alb, TBIL, Ca, CO2, Creat, Glu, AikP, TP, Na, SGOT, BUN, SGPT, Cl, K) <input type="checkbox"/> 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	
<input checked="" type="checkbox"/> CBC		
<input checked="" type="checkbox"/> PT/PTT/NR	Patients whose surgery is likely to be performed under regional anesthesia and are taking or have recently taken anticoagulant drugs	
<input checked="" type="checkbox"/> Urinalysis		
<input type="checkbox"/> HCG Serum <input type="checkbox"/> HCG Urine	If the patient is a woman of childbearing age	
<input checked="" type="checkbox"/> 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)	
<input type="checkbox"/> Chest X - Ray  Chest Xray is not required if patient's condition is stable	Patients who have chronic pulmonary disease (emphysema, bronchitis, asthma), chronic congestive heart failure or who have experienced a recent exacerbation of symptoms deviating from a stable state	
<input type="checkbox"/> 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# \_\_\_\_\_



# 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: \_\_\_\_\_



**Northwell Health**

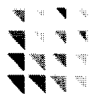
**Greenwich Village Ambulatory Surgery Center**

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

			Yes	No
Name: _____	Do you get short of breath if you do not sleep on 2 or more pillows?	<input type="checkbox"/>	<input type="checkbox"/>	
DOB: _____ Height _____ Weight _____ BMI _____	Have you had a recent cough cold, fever, infection?	<input type="checkbox"/>	<input type="checkbox"/>	
Telephone Number: _____	Do you have asthma, bronchitis, emphysema or history of pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>	
Preferred Language: _____	Do you have stomach problems (ulcer or heartburn)?	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency Contact: _____	Do you have a hiatal hernia?	<input type="checkbox"/>	<input type="checkbox"/>	
Relationship: _____ Number: _____	Have you ever been treated for anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Last Menstrual Period: _____	Do you have sickle cell anemia or trait?	<input type="checkbox"/>	<input type="checkbox"/>	
Primary Medical Doctor: (Name & number) _____	Do you bruise or bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiologist (if applicable): _____	Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies: (including food, latex, dyes) _____	Have you ever had kidney failure, stones or infections?	<input type="checkbox"/>	<input type="checkbox"/>	
List all meds that you take regularly (Use attached sheet) : <input type="checkbox"/> None	Do you have thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	Do you have liver disease (cirrhosis or hepatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	Do you have arthritis of your jaw, neck or back?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take Aspirin/blood thinners? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name: _____ Last taken: _____	Do you have difficulty opening your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes, How many packs per day? _____	Any history of seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
How often do you drink? <input type="checkbox"/> Seldom <input type="checkbox"/> Socially <input type="checkbox"/> Heavily	Have you ever had a stroke or temporary blackout?	<input type="checkbox"/>	<input type="checkbox"/>	
List all operations that you've had and year of surgery: _____	Have you had a significant weight loss in the last 6 months without dieting?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	Do you have or have been diagnosed with Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	If yes, do you use CPAP?	<input type="checkbox"/>	<input type="checkbox"/>	
_____	Do your calves get cramps when you walk a short distance?	<input type="checkbox"/>	<input type="checkbox"/>	
If you answered yes to any question please explain below:				
Have you been hospitalized for any medical conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, Explain _____	_____			
_____	_____			
Have you had any problems with anesthesia in the past? Describe: _____	_____			
Any anesthetic problems in your family: _____	_____			
	Escort (Adult > 18 yrs old) Name: _____	Number: _____		
Do you have any loose teeth, dentures or caps? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Past history of drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient or Person completing form _____	Date _____		
Do you have high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Do you get chest pain (angina)? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Have you had a heart attack or congestive heart failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia Review (Signature) <input type="checkbox"/> approved <input type="checkbox"/> not approved Date & time _____			
Do you get palpitations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Notes: _____			
Have you ever had rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Do you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Do you have a pacemaker/AICD? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Place Patient Label Here				



**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 3/4" 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

