Printed on :

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #			

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			

SURGICARE OF BROOKLYN

313 43rd St, Brooklyn, NY 11232
Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468
Email: verification@starssi.com

Patient Email: _____

Surgical Booking Form

Patient Information

LAST	FIRST	MI	M F	DOB	AGE

STREET ADDRESS	SOCIAL SECURITY #

CITY	STATE	ZIP	EMERGENCY CONTACT

HOME #	WORK #	CELL #	EMERGENCY #

Surgical Procedure Information

SURGEON **Dr. Upendra Sinha**	ASSISTING SURGEON

REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE

PRIMARY PROCEDURE NAME	LEFT RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4

SURGICAL DIAGNOSIS NAME	LEFT RIGHT	ICD-9 CODE #1	ICD-9 CODE #2	ICD-9 CODE #3	ICD-9 CODE #4

Pre-Operative Medical Clearance

DOES THE PATIENT REQUIRE PRE-OP MEDICAL CLEARANCE? YES NO	IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:

DOES THE PATIENT REQUIRE AN EKG? YES NO	PATIENT HEIGHT	PATIENT WEIGHT

Special Requests

EQUIPMENT **Smith & Nephew**	SUPPLIES

INSTRUMENTATION	OTHER

Insurance Information

IS THIS WORKMAN'S COMP? YES NO IS THIS NY NO FAULT? YES NO IS THIS PRIVATE HEALTH INS? YES NO	**PLEASE ATTACH AUTHORIZATION LETTER**	CASE CLAIM #	DATE OF INJURY

IS THIS A LIEN? YES NO **PLEASE ATTACH SIGNED LIEN**	ATTORNEY NAME	ATTORNEY PHONE #

PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB

POLICY #	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER

SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB

POLICY #	RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.

Surgeon's Scheduler's Information

NAME	PHONE #	FAX #

Treating Physical Therapy Office

NAME	PHONE #	ADDRESS

Transportation:
X☐ YES ☐ NO

SCOB, LLC 313 43rd Street • Brooklyn, NY 11232

Information and Consent for Procedure

I hereby authorize the following doctor(s): Dr. Upendra Sinha and any such assistants a may be selected by him/her to perform the following procedure(s) on me:
Left Knee arthroscopy, meniscectomy, shaving chondroplasty and related procedures.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of the procedures.

It has been explained to me that during the course of the procedures, unforeseen conditions may be revealed that necessitate additional or different procedures than those set forth in paragraph 1. I, therefore, authorize and request that the above named practitioner(s), his/her assistants, or his/her designees perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph 3 shall extend to treating all conditions that are not known at the time the procedure is undertaken.

I have been informed of the risks that are generally associated with the performance of any procedure and the administration of anesthesia, I further understand that there may be serious consequences such as headaches, neurological or sensory disturbances, bowel/bladder dysfunction, infection, soreness, permanent pain, delayed healing, numbness, tingling, non-healing, need for future procedures or other calamitous occurrence. I understand that there may be certain risks especially associated with the procedures described in paragraph 1. I have asked and am satisfied that I know to the extent that I wish to know what those risks may be. I accept those risks.

I consent to the photographing or videotaping of the surgery or procedure(s) to be performed, including appropriate portions of my body for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by descriptive text accompanying them.

I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives or appropriate parties approved by my surgeon.

I authorize and consent the surgery center to perform any blood tests, including but not limited to, tests for HIV, Hepatitis B, and Hepatitis C on any patient, during whose treatment a healthcare professional sustains a puncture, mucous membrane or open wound exposure to the patient's blood or other bodily fluids.

I consent, authorize and request the administration and management of such anesthesia as is deemed suitable by the anesthesiologist assigned to my procedure. It is my understanding that the anesthesiologist will have full charge of the administration and management of the anesthesia and any other necessary, associated procedures for anesthesia.

I acknowledge that the foregoing information does not cover all of the specific information that has been provided by the above named practitioner. But, the information set forth above was provided to me and I have had full opportunity to ask questions and to have received additional information.

I have apprised the patient of the foregoing.

____/____/____ Date _____ Time

_____ Patient Signature/or Authorized Representative _____ Witness/Interpreter Signature _____ Physician Signature

The patient is unable to sign because _____, I therefore consent for the patient.

_____ Person signing on behalf of the Patient _____ Relationship to the Patient

INTRAOPERATIVE FINDINGS

Right / Left KNEE

__ MMT (51) _____

__ LMT (52) _____

__ Partial/Complete tear of the ACL: %_____(53)

__ Patella, grade: 1 2 3 4 (54) _____

__ Trochlea, grade: 1 2 3 4 (55) _____

__ LFC, grade: 1 2 3 4 (56) _____

__ MFC, grade: 1 2 3 4 (57) _____

__ LTP, grade: 1 2 3 4 (58) _____

__ MTP, grade: 1 2 3 4 (59) _____

_____

grade: 1 2 3 4 (60) _____

__ Loose fragments (61) _____

__ Medial plica (62) _____

__ Synovitis (63) _____

__ Adhesions- anterior wall / suprapatellar pouch (64)

_____

__ Other: _____

_____

Preoperative Dx: _____

_____

Assistant: _____

Anesthesia: _____

Instrumentation/Other: _____

_____

Right / Left KNEE

CPT CODES (PROCEDURES)	ICD-10 CODES (POST-OP DIAG)
___27570 MVA. (51)	___M22.40 Chondromalacia patella. (51)
___29870 Diagnostic arthroscopy; Knee. (52)	___M23.40 Loose body in knee. (52)
___29873 SAK; with lateral release. (53)	___M23.90 Internal derangement of knee. (53)
___29874 with removal of loose body or foreign body. (54)	___S83.241A Medial meniscus tear, rt knee. (54)
___29875 Limited synovectomy (plica resection). (55)	___S83.242A Medial meniscus tear, left knee. (55)
___29876 Synovectomy (major; 2 or more compartments). (56)	___S83.281A Lateral meniscus tear, rt knee. (56)
___29877 Debridement (chondroplasty). (57)	___S83.282A Lateral meniscus tear, left knee. (57)
___29879 Microfracture abrasion chondroplasty. (58)	___M12.569 Traumatic arthropathy of knee. (58)
___29880 PMM and PLM. (59)	___M65.161 Synovitis, right knee. (59)
___29881 PMM or PLM. (60)	___M65.162 Synovitis, left knee. (60)
___29882 MED or LAT meniscus repair. (61)	___M24.10 Chondral lesion, right knee. (61)
___29883 MED and LAT meniscus repair. (62)	___M24.10 Chondral lesion, left knee. (62)
___29888 ACL reconstruction. (63)	___M93.261 Osteochondral lesion, right knee. (63)
___20610 Arthrocentesis (aspiration and/or inject) of a joint. (64)	___M93.262 Osteochondral lesion, left knee. (64)
___29999 Coblation arthroplasty, patella. (65)	
___29884 Lysis of adhesions/suprapatellar pouch/ant. wall. (66)	

___ No Medial/Lateral Meniscal tear seen (51)

___ Medial/Lateral Meniscectomy (52)

___ Medial/Lateral Meniscal Repair (53)

___ Debridement of ACL (54)

___ Major Synovectomy (55)

___ Chondroplasty (Medial/lateral) Condyle (56)

___ Chondroplasty (Patella/Trochlea) (67)

___ Chondroplasty (medial/lateral) tibial plateau (57)

___ Abrasion Chondroplasty (Medial/Lateral condyle) (medial/lateral tibial plateau) (patella/trochlea) (58)

___ Coblation Arthroplasty (Medial/Lateral condyle) (patella/ trochlea) (59)

___ Coblation Arthroplasty (Medial/Lateral) tibial plateau (60)

___ ACL Reconstruction (61)

___ Lateral Release (62)

___ Removal of Loose Bodies (63)

___ Medial Plica Excision (64)

___ Lysis of Adhesions (65)

___ Bilateral Meniscectomy (66)

Pre-Op Knee Template: Left / Right
WC NF Lien Other

Rec #: _____ Location: _____

__MVA __Seat belt __Driver __Front Passenger __Rear Passenger

__bike __pedestrian

Working: __N __Y Stopped: _____ Returned: _____ Returning: _____

Restrictions: __N __Y: _____

Receiving PT: __N __Y: _____

Taking med. for pain: __N __Y: _____

Knee pain: __1 __2 __3 __4 __5 __6 __7 __8 __9 __10/ 10 __constant __intermittent

Worsens: __ROM __walking __standing __squatting

Radiates: __up thigh __down leg

There is __clicking __buckling __numbness/tingling __giving way __locking

Knee: __within normal limits

Inspection: __normal.

Swelling over the __anterior __posterior aspect __suprapatellar __para patella __subpatellar aspect __medial __lateral joint line.

Ecchymosis over the __anterior __posterior aspect __suprapatellar __para patella __subpatellar aspect __medial __lateral joint line.

Palpation: __normal.

Tenderness over the __anterior __posterior aspect __suprapatellar __para patella __subpatellar aspect __medial __lateral joint line.

Effusion __anterior __posterior aspect __suprapatellar __para patella __subpatellar aspect __medial __lateral joint line.

ROM: __normal Strength: __normal

__limited __numbness __pain __clicking	NORM	CLAIMANT	__ Improving __partial
Flexion	140	degrees	/5
Extension	0	degrees	/5

Tests:

McMurray Test	__Pos __Neg	Apley's Test	__Pos __Neg
Lachman's Test	__Pos __Neg	Posterior Drawer	__Pos __Neg
Valgus Stress Test	__Pos __Neg	Anterior Drawer	__Pos __Neg
Varus Stress Test	__Pos __Neg	Pivot Shift Test	__Pos __Neg
Ballottement Test	__Pos __Neg	Patellofem. Crepitus	__Pos __Neg
Squat Test	__Pos __Neg		

DX:

__ Medial meniscus tear __ Lateral meniscus tear __ Medial & lat meniscus tear

__ ACL tear __ Strain MCL __ Strain ACL

__ Joint effusion __ Chondromalacia __Internal derangement

Findings from Pre-op sheet __loose bodies

_____

__Patient is currently 100% 75% 50% 25% __ temporarily totally / partially disabled.

Recommendation: _____

_____

_____