

Patient Information

Personal Information			
First Name	EMILY	Middle Name	-
Last Name	EDWARDS	D.O.B	01/24/2003
Gender	Female	Address	423 SOUTH FULLTON AVE APT3
City	MOUNT VERNON	State	NEW YORK
Cell Phone #	347-206-6391	Home Phone	718-881-5845
Work	-	Zip	10553
Email	-	Extn.	-
Attorney	DOMINICK LAVELLE	Case Type	No-Fault
Attorney Address	100 HERRICKS ROAD SUITE 201	Attorney Phone	800-745-4878
Case Status	OPEN	SSN	-

Insurance Information			
Policy Holder	-	Name	LIBERTY MUTUAL INS.
Address	P.O. Box# 1052	City	Montgomeryville
State	PENNSYLVANIA	Zip	18936-1052
Phone	800 245-1700	Fax	-
Contact Person	-	Claim File #	034381648
Policy #	AOS228001979405		

Accident Information			
Accident Date	09/14/2016	Plate Number	-
Report Number	-	Address	-
City	-	State	-
Hospital Name	-	Hospital Address	-
Date of Admission	-	Additional Patient	-
Describe Injury	-	Patient Type	Passenger

Employer Information			
Name	-	Address	-
City	-	State	-
Zip	-	Phone	-
Date of First Treatment	-	Chart #	-

Adjuster Information			
Name	-	Phone	-
Extension	-	Fax	-
Email	-		



92-12 165th St, Jamaica, NY 11433

Phone: 201-549-9998 Ext. 1279 Fax: 646-585-4468

Email: verification@starssi.com

Patient Email: _____

Surgical Booking Form

Patient Information

LAST	FIRST	MI	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	AGE
STREET ADDRESS				SOCIAL SECURITY #	
CITY	STATE	ZIP	EMERGENCY CONTACT		
HOME #	WORK #	CELL #	EMERGENCY #		

Surgical Procedure Information

SURGEON Dr. Anjani Sinha		ASSISTING SURGEON			
REQUEST DATE #1	TIME	REQUEST DATE #2	TIME	LENGTH OF CASE	
PRIMARY PROCEDURE NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	CPT CODE #1	CPT CODE #2	CPT CODE #3	CPT CODE #4
SURGICAL DIAGNOSIS NAME	<input type="checkbox"/> LEFT <input type="checkbox"/> 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?		IF YES, NAME OF CLEARING PHYSICIAN AND PHONE #:	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
DOES THE PATIENT REQUIRE AN EKG?		PATIENT HEIGHT	PATIENT WEIGHT
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			

Special Requests

EQUIPMENT Smith & Nephew	SUPPLIES
INSTRUMENTATION	OTHER

Insurance Information

IS THIS WORKMAN'S COMP?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE ATTACH	CASE CLAIM #	DATE OF INJURY
IS THIS NY NO FAULT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	AUTHORIZATION LETTER		
IS THIS PRIVATE HEALTH INS?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
IS THIS A LIEN?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ATTORNEY NAME	ATTORNEY PHONE #	
PLEASE ATTACH SIGNED LIEN				
PRIMARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			
SECONDARY INSURANCE	SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DOB	
POLICY #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER			
EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #		

Insurance Pre-Certification Authorization

INSURANCE COMPANY PHONE #	INSURANCE CO. REPRESENTATIVE	AUTH #	DATE OF AUTH.
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Surgeon's Scheduler's Information

NAME	Clara Clement	PHONE #	347-433-4855	FAX #	929-333-7950
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Treating Physical Therapy Office

NAME	PHONE #	ADDRESS
Transportation: <input type="checkbox"/> YES <input type="checkbox"/> NO		

Information and Consent for Procedure

I hereby authorize the following doctor(s): Christopher S. Durant and any such assistants as may be selected by him/her to perform the following procedure(s) on me:

Right Shoulder Arthroscopy, rotator cuff/labral repair, partial acromioplasty and related procedure.

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

Right / Left SHOULDER

CPT CODES (PROCEDURES)

ICD-10 CODES (POST-OP DIAG)

- ___ 29805 Shoulder diagnostic. (10)
- ___ 29823 Major debridement. (11)
- ___ 29822 Minor debridement. (12)
- ___ 29820 Minor synovectomy. (13)
- ___ 29821 Complete synovectomy. (14)
- ___ 29819 Loose body removal or fragments. (15)
- ___ 29999 Coblation arthroplasty glenoid. (16)
- ___ 29824 Distal claviclectomy. (17)
- ___ 29825 Lysis of adhesions. (18)
- ___ 29999 Bursectomy. (19)
- ___ 29826 Decompression, partial acromioplasty. (20)
- ___ 29999 Release of CA ligament. (21)
- ___ 20610 Intraarticular injection. (22)
- ___ 29827 RC repair arthroscopically. (23)
- ___ 29807 Slap repair. (24)
- ___ 29806 Bankart repair, capsulorrhaphy. (25)
- ___ 29828 Biceps tenodesis. (26)
- ___ 23770 Manipulation should under anesthesia. (27)
- ___ 23405 Shoulder tenotomy. (28)
- ___ 29999 Topaz microdebridement. (29)
- ___ 29999 Chondroplasty (glenoid/humeral head). (30)

- ___ M75.01 Adhesive capsulitis, right shoulder. (10)
- ___ M75.02 Adhesive capsulitis, left shoulder. (11)
- ___ S46.101A Biceps tendon tear, right shoulder. (12)
- ___ S46.102A Biceps tendon tear, left shoulder. (13)
- ___ M75.41 Impingement syndrome, right shoulder. (14)
- ___ M75.42 Impingement syndrome, left shoulder. (15)
- ___ M24.811 Internal derangement, right shoulder. (16)
- ___ M24.812 Internal derangement, left shoulder. (17)
- ___ M75.121 Complete rupture, rot. cuff, rt shoulder. (18)
- ___ M75.122 Complete rupture, rot. cuff, left shoulder. (19)
- ___ S46.011A Partial rotator cuff tear, right shoulder. (20)
- ___ S46.012A Partial rotator cuff tear, left shoulder. (21)
- ___ S43.431A Labrum tear, right shoulder. (22)
- ___ S43.432A Labrum tear, left shoulder. (23)
- ___ M65.811 Synovitis, right shoulder. (24)
- ___ M65.812 Synovitis, left shoulder. (25)
- ___ M75.51 Bursitis, right shoulder. (26)
- ___ M75.52 Bursitis, left shoulder. (27)
- ___ M24.10 Glenoid chondral defect. (R 28, L 29)
- ___ M75.81 Subacromial adhesions. (R 30, L 31)

___ 29999 Chondroplasty (glenoid/humeral head). (30) Templates Chondromalacia (glenoid/hum. head) (R 32, L 33)

- ___ Synovectomy (10)
- ___ Posterior Capsular Release (12)
- ___ Anterior Labrum Bankart tear with no repair (13)
- ___ Anterior labral Bankart tear with repair (16)
- ___ Anterior labral tear, no repair (14)
- ___ Inferior labral tear, no repair (15)
- ___ Biceps tear with debridement (19)
- ___ Biceps tear with tenotomy (20)
- ___ Biceps tear with tenodesis (21)
- ___ Supraspinatus Tear with no repair (27)
- ___ Infraspinatus Tear with no repair (28)
- ___ Removal of Loose Bodies (32)
- ___ Subacromial Bursectomy (33)
- ___ Subacromial Decompression with Acromioplasty (34)
- ___ Subacromial Decompression without Acromioplasty (35)
- ___ Lysis of Adhesions (42)
- ___ RC tear with rep. of BioInductive Implant/PLGA Anchor (39)

- ___ Anterior Capsular Release (11)
- ___ SLAP with no repair (17)
- ___ SLAP with repair (18)
- ___ Posterior Labral tear without repair (22)
- ___ Posterior Labral tear with repair (23)
- ___ Subscapularis Tear with no repair (24)
- ___ Subscapularis Tear with repair, no anchor (25)
- ___ Subscapularis Tear with repair, with anchor (26)
- ___ Chondroplasty of the Humeral Head (29)
- ___ Chondroplasty of the Glenoid (30)
- ___ Coblation Arthroplasty of the Glenoid (31)
- ___ Lysis of the Coracoacromial Ligament (36)
- ___ Distal Clavicle Mumford Procedure (37)
- ___ Rotator Cuff tear with no repair (38)
- ___ Rotator Cuff Tear with Repair, 1 anchor (40)
- ___ Rotator Cuff Tear with Repair, 2 anchors (41)
- ___ Topaz microdebridement (43)

INTRAOPERATIVE FINDINGS

Right / Left SHOULDER

- ___ Labral tear (anterior, posterior, superior, inferior) (10) _____
- ___ Partial intraarticular rotator cuff tear (11) _____
- ___ Partial bursal-side rotator cuff tear (12) _____
- ___ Chondromalacia glenoid (13) _____
- ___ Chondromalacia humeral head (14) _____
- ___ Loose fragments (15) _____
- ___ SLAP tear (16) _____
- ___ Full thickness rotator cuff tear (17) _____
- ___ Partial thickness rotator cuff tear (18) _____
- ___ Bankart lesion (19) _____
- ___ Biceps tendonitis (20) _____
- ___ Biceps tendon tear (21) _____
- ___ Partial biceps tear (22) _____
- ___ Synovitis (23) _____
- ___ Subacromial adhesions (24) _____
- ___ Adhesive Capsulitis (25) _____
- ___ Impingement (26) _____
- ___ Subscapularis tendon tear (27) _____
- ___ Glenoid chondral lesion (28) _____
- ___ Bursitis (29) _____

Preoperative Dx: _____

Assistant: _____

Anesthesia: General, IV Sedation, Nerve block _____

Instrumentation/Other: _____

pPre-Op Shoulder 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: _____

Shoulder pain: __1 __2 __3 __4 __5 __6 __7 __8 __9 __10/ 10 __constant __intermittent
Worsens: __ROM __LPP __reaching overhead __grooming
Radiates: __to trap __down arm
There is __clicking __numbness/tingling

Shoulder: __within normal limits

Inspection: __normal.

Swelling over the __AC joint __anterior __lateral __posterior __SC joint __upper arm __scapula.
Erythema over the __AC joint __anterior __lateral __posterior __SC joint __upper arm __scapula.
Ecchymosis over the __AC joint __anterior __lateral __posterior __SC joint __upper arm
__scapula. Atrophy is __posterior __superior __anterior.

Palpation: __normal.

Tenderness over __AC joint __anterior __lateral __posterior __SC joint __upper arm __scapula.
Spasm of the __trap __upper thoracic muscles. Crepitus at the __AC joint __glenohumeral
__scapula

ROM: __normal

Strength: __normal

__limited __painful	NORM	CLAIMANT	__Improving __partial
Abduction	180	degrees	/5
Adduction	30	degrees	/5
Forward Flexion	180	degrees	/5
Extension	60	degrees	/5
Internal Rotation	80	degrees	/5
External Rotation	90	degrees	/5

Tests: __normal

Apprehension __Pos __Neg
Relocation is __Pos __Neg
Impingement is __Pos __Neg
O'Brien's test __Pos __Neg

Hawkin's Test __Pos __Neg
Drop arm test __Pos __Neg
Arc of pain __Pos __Neg

DX:

__ Rot. cuff tear __ Labral tear __ SLAP tear __ Impingement
__ Bursitis __ Tendinitis __ capsulitis

Findings from Pre-op sheet

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

