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** | | | |

CITIMED SURGERY CENTER

**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 | M F | DOB | AGE |
|---|---|---|---|---|---|
| | | | | | |

| STREET ADDRESS | SOCIAL SECURITY # |
|---|---|
| | |

| CITY | STATE | ZIP | EMERGENCY CONTACT |
|---|---|---|---|
| | | | |

| HOME # | WORK # | CELL # | EMERGENCY # |
|---|---|---|---|
| | | | |

## *Surgical Procedure Information*

| SURGEON | ASSISTING SURGEON |
|---|---|
| Dr. Upendra Sinha | |

| 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 | SUPPLIES |
|---|---|
| Smith & Nephew | |

| INSTRUMENTATION | OTHER |
|---|---|
| | |

## *Insurance Information*

| | | | | |
|---|---|---|---|---|
| IS THIS WORKMAN'S COMP? ☐ YES ☐ NO | **PLEASE ATTACH** | CASE CLAIM # | DATE OF INJURY |
| IS THIS NY NO FAULT? ☐ YES ☐ NO | **AUTHORIZATION LETTER** | | |
| IS THIS PRIVATE HEALTH INS? ☐ YES ☐ NO | | | |
| 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 # |
|---|---|---|
| Clara Clement | 347-433-4855 | 929-333-7950 |

## *Treating Physical Therapy Office*

| NAME | PHONE # | ADDRESS |
|---|---|---|
| | | |

**Transportation:**
☐ 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: _____

_____

_____