Surgical Center
444 Market St Suite 1
Saddle Brook NJ 07663
Tel: (201)843-9441 Fax:(201)843-9442

005AProduct: Medline Hemo-force

I am prescribing a Medline Hemo-force System for use during the intra-op and immediate post-op phase during my patient's care. I certify that the Hemo-force Device is medically indicated, and in my opinion, a reasonable prophylactic measure with the reference to the accepted standards of medical practice and treatment to promote optimal blood flow that may be compromised during a surgical procedure.

Medline Hemo-Force:

☐ **Sleeves (bilateral application)**

☐ **Sleeves (unilateral-only applicable for ankle/ knee procedures)**

Physician's Letter of Medical Necessity

In my evaluation of this patient, I have noted that there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed in combination with other risk factors. I am prescribing DVT Prophylaxis involving the use of sequential compression device and the necessary application which will significantly decrease the risk factors associated with a DVT, such as Pulmonary Embolism (PE). Deep vein thrombosis and it's known complications such as a pulmonary embolism can have major complications associated with these surgeries, resulting in significant morbidity and mortality rates, as stated by the American College of Chest Physicians.

Significant published data is available on the incidents of DVT/PE, the effectiveness of various prophylactic techniques, and the risk of hemorrhage when heparin is used, all of which provide positive and compelling evidence in support for the use of intermittent compression devices in DVT prevention. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma and other conditions that impede, or significantly decreased ambulation of patients most and certainly will decrease circulation which can result in edema, pain, delayed healing and increase risk of DVT and PE. The clinical trials show clear evidence that these complications and risk factors can be significantly minimized with the use of the pneumatic compression devices.

For these reasons, sequential compression sleeves are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I have successfully used this device in my practice and patients tolerate the treatment protocol with a very high degree of compliance. I feel this protocol is the most beneficial and cost-effective treatment for my patients in greatly reducing the development of DVT, which when ignored can result in significant increase in morbidity and mortality and increased utilization of health care resources and dollars.

My signature below acknowledges, that in my professional judgment, the prescribed item is medically indicated & necessary. The information is consistent with the most current literature and accepted standards of care for the surgical patient and it's improved post-operative outcomes.

Physician Name: _____ NPI: _____
Physician Address: _____
City: _____State: _____Zip Code: _____Phone: _____
Physician Signature: _____Date: _____

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CONSENT FOR OPERATION **Date:** _____

Patient: _____ **Time:** _____

I, _____, authorize Dr. _____ and such associates as may be assigned by her / him to perform, or have performed on me by authorized Surgicore Surgical Center personnel or consultants, the following: _____

_____

Dr. _____ and / or Dr. _____ have explained the procedures to be performed to me and I understand the nature of the procedure to be: (Describe the procedure in language of the layman) _____

_____

_____

I recognize that during the course of the procedure or operation, unforeseen conditions may necessitate additional or different procedures other that set forth in paragraph 1 and 2. Therefore, request that the above-named surgeon his associates and assistants, or his designees, perform such procedures as are in exercise of professional judgment necessary and desirable, including, but not limited to procedures involving surgery. The authority granted under this paragraph 2 should extend to treating all conditions that require treatment and are not known to Dr._____ at the time the operation is performed.

I have been made aware of the risk(s) and the consequence(s) that are associated with the procedure(s) described in the above paragraphs. These are: _____

_____

I have also been informed that there are risks such as blood loss, infection, cardiac arrest, etc. that are attendant to the performance of any surgical procedures. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation and procedures.

I consent to the administration of anesthesia and understanding there are risks associated with anesthesia.

I understand that among those who attend patients at this center are medical, nursing, and other health care personnel in training who unless I expressly request otherwise, may be present and / or may participate in patient care under proper supervision as part of their medical education.

I understand that photography is important in planning and evaluating surgery and I give permission for photography to be taken before, during and after my surgery for documentation only.

I consent to the disposal by Surgicore Surgical Center authorities of any tissue or body parts which may be removed.

_____	_____	_____
Signature of Patient/Guardian (If Minor)	Signature of Witness	Signature of Informant Doctor

Dt of Proc

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Pre-Surgical Clearance
History & Physical

Date:_____

Planned Procedure:_____

MEDICAL HISTORY

Chief Complaint:_____

_____

_____

Past Medical History:_

Past Surgical History:_____

Social History:_____

Allergies:_____

Medications:_____

Patient on Aspirin:_____ Patient on Anti-Inflammatory:_____

PHYSICAL EXAMINATION

Temp:_____ Pulse:_____ Resp: _____ BP:_____ WT:_____ HT:_____

PLEASE CHECK IF NORMAL

HEET	☐ *NORMAL*	☐ *OTHER:*_____
CARDIOVASCULAR	☐ *NORMAL*	☐ *OTHER:*_____
THORAX / LUNGS	☐ *NORMAL*	☐ *OTHER:*_____
ABDOMEN	☐ *NORMAL*	☐ *OTHER:*_____
EXTREMETIES	☐ *NORMAL*	☐ *OTHER:*_____
NEUROLOGICAL	☐ *NORMAL*	☐ *OTHER:*_____
GENITAL / RECTUM	☐ *NORMAL*	☐ *OTHER:*_____
LAB VALUES	☐ *NORMAL*	☐ *OTHER:*_____
POC TESTING	☐ *NORMAL*	☐ *OTHER:*_____
EKG	☐ *NORMAL*	☐ *OTHER:*_____
CXR	☐ *NORMAL*	☐ *OTHER:*_____

Patient was evaluated today, and patient is proceeding with the proposed procedure as mentioned in the consent form.

Patient medically cleared for surgery Yes _____ NO _____

Provider Signature _____ MD / DO / PA / NP Date: _____

Surgical Physician / Anesthesiologist _____ Date:_____

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PROGRESS NOTES

Doctor: _____

Date: _____

Patient: _____

See OP Report

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Should this be aken from

REPORT FOR OPERATION

Pre-Op DX:

Post-Op DX:

Operation:

Estimated Blood Loss: 0 Tourniquet Used: YES Or NO

Surgeon: Dr. Assistant:

Intra-Op Complications: Stable, None

Condition upon Arrival at PACU: Stabl

Instruction Given: ☐ Yes ☐ NO

Dictation Done: ☐ Yes ☐ NO

Post Op Meds Given: ☐ Yes ☐ NO

Physicians Signature: Date:

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Physicians Orders

Patient Allergic to:

None Aspirin Sulfa Penicillin NSAIDS

Other: _____

- ☐ Oxygen at 3 liters upon arrival to PACU
- ☐ Vital signs as per PACU routine unless otherwise noted by Anesthesiologist
- ☐ IV Lactated Ringers / NACL till tolerating PO then D/C
- ☐ Regular Diet
- ☐ OOB to ambulate
- ☐ Pain medication as per Physician / Anesthesiologist
- ☐ Patient may be D / C when awake and alert and vital signs are stable

_____

Doctors Signature Date / Time Nurse Signature

Date / Time	Standing Order
	Dilaudid_____mg IV x _____ every _____ minute PRN Pain max dose
	Demerol _____ mg IV x _____ every _____ minute PRN Pain max dose
	Percocet _____ mg _____ tablet / tablets po x _____ PRN Pain
	Zofran 4mg IV x _____ PRN nausea
	Reglan 10mg IV x _____ PRN nausea
	Tigan _____mg Im x _____ PRN nausea

Orders

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PHYSICIAN PRE-OPERATIVE ORDER SHEET

- ☐ VITAL SIGNS AS PER ROUTINE PROTOCOL
- ☐ HCG (IF APPLICABLE)
- ☐ APPLY PNEUMATIC COMPRESSION DEVICE (DVT PROPHYLAXIS)
- ☐ FBS CHECK FOR ALL DIABETIC PATIENTS; RESULTS: _____
- ☐ START IV ACCESS AT KEEP VEIN OPEN
  - ☐ NORMAL SALINE
  - ☐ 1000ML
  - ☐ 500ML
  - ☐ 250ML

  - ☐ LACTATED RINGERS
  - ☐ 1000ML
  - ☐ 500ML
  - ☐ 250ML

- ☐ OTHER: _____

- ☐ ALLERGIES: _____

MEDICATION

- ☐ ANCEF 1GM
- ☐ ANCEF 2GM
- ☐ CLINDAMYCIN 600MG
- ☐ INSULIN
- ☐ OTHER: _____

_____ _____

PHYSICIAN SIGNATURE TIME NURSE TIME

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CONSENT FOR ANESTHESIA

I, _____ acknowledge that the doctor has explained to me that I will have an operation or procedure, and that anesthesia services are needed. I have received an explanation of the potential benefits, risks, potential problems, likelihood of success, and alternatives. The doctors have explained the risks of anesthesia and I understand that no guarantee can be made concerning the results of anesthesia. Although rare, unexpected severe complications can occur, and include but are not limited to the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand these risks apply to all forms of anesthesia. I understand that the type of anesthesia specific below will be used for my procedure and the type of anesthesia was chosen based on factors including my physical condition, the type of procedure I will have performed, the physician's preference and my own preference. It has been explained that sometimes local anesthesia with or without sedation may not succeed completely and that I may then need another type of anesthesia including general anesthesia.

☐ General Anesthesia	Technique Benefits Risks	Drug is injected into the bloodstream or breathes into the lungs by use of mask. A breathing tube may be placed in the windpipe. I will be completely asleep, unconscious. Mouth or throat pain, hoarseness, injury to mouth or teeth, injury to blood vessels, pneumonia, awareness under anesthesia, saliva or vomit drawn into the lungs.
☐ Deep Sedation	Technique Benefits Risks	Drug is injected into the bloodstream I will be asleep, unconscious. Injury to blood vessels, pneumonia, saliva or vomit drawn into lungs. Possible need to have a breathing tube placed in the windpipe.
☐ Spinal or Epidural Analgesia / Anesthesia ☐ With Sedation ☐ Without Sedation	Technique Benefits Risks	Drug is injected through a needle or catheter placed into the spinal canal or just outside the spinal canal. Temporary loss of feeling and / or movement of the lower part of the body Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injured to blood vessels, low blood pressure, breathing and circulation problems.
☐ Major/Minor Nerve Block ☐ With Sedation ☐ Without Sedation	Technique Benefits Risks	Drug is injected near nerves. Provides temporary loss of feeling and / or limb movement to a specific limb area Infections, convulsions, weakness, persistent numbness, residual pain, injured to blood vessels.
☐ Intravenous Regional ☐ With Sedation ☐ Without Sedation	Technique Benefits Risks	Drug is injected into the veins of an arm or leg while using a tourniquet. Provides temporary loss of feeling and /or movement of limb Infections, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels
☐ Moderate Sedation	Technique Benefits Risks	Drug is injected into the blood stream or may be given by mouth or other routes. Moderate sedation results in reduced anxiety and pain, reduced awareness of surroundings, partial or total amnesia. Deep sedation results in an unconscious state. Moderate sedation risk complete unconscious state slowed breathing, injury to blood vessels.

I hereby consent to the Anesthesia service checked above and authorize that it be given by Dr. _____ or his / her associates. I also consent to an alternative type of anesthesia if the physician decides it is necessary or appropriate for me. I certify and acknowledge that I have read this form, or it was read to me, that I understand the benefits, risks, and alternatives of the anesthesia services, and I had time to ask questions and have them answered.

_____ _____
Patient Signature Date Witness Date / Time

Physician Certification: I,_____, M.D, certify that I have explained the anesthesia plan and attendant risks, benefits, and alternatives to the above named patient or authorized healthcare representative who has signed the form.

Physician Signature:_____Date:_____ Time:_____

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ANESTHESIA RECORD

PATIENT (Last, First, M)	ACCOUNT NO.	MARITAL STATUS	BIRTHDATE	AGE	SEX	ICD-9 CODE	PROCEDURE CODE

DATE OF SURGERY	SCHED. TIME	SURGEON	ADMITTING DIAGNOSIS	HOME PHONE

PROPOSED PROCEDURE	PATIENT SOCIAL SECURITY NO.	BUSINESS PHONE

PRE-ANESTHESIA EVALUATION

Height	ROS	ETOH	CURRENT MEDICATIONS
Weight	Heart	Smoking	
B.P	Lungs	LMP	
Pulse	Renal	Steroids	ALLERGIES
Temp	Hepatic	Bleeding	
RESP	Diabetes	Neuro	PREVIOUS SURGERY HX
Sa02	Dentures	C. Lenses	

MEDICAL HISTORY

ANESTHESIA HX

FAMILY HX ANES

PERTINENT LAB FINDINGS

SIGNIFICANT PAST HISTORY:

ECG TRACE

PRE-OPERATIVE EVALUATION- PHYSICAL EXAM

MENTAL STATUS:

HEAD	CONDITION OF TEETH:	AIRWAY ACCESSS MAL I ☐ II ☐ III ☐ IV ☐
CHEST	ANESTHESIA PLAN: DISCUSSED WITH PATIENT _____ ANESTHESIOLOGISTS SIGNATURE	
HEART	OTHER FINDINGS:	

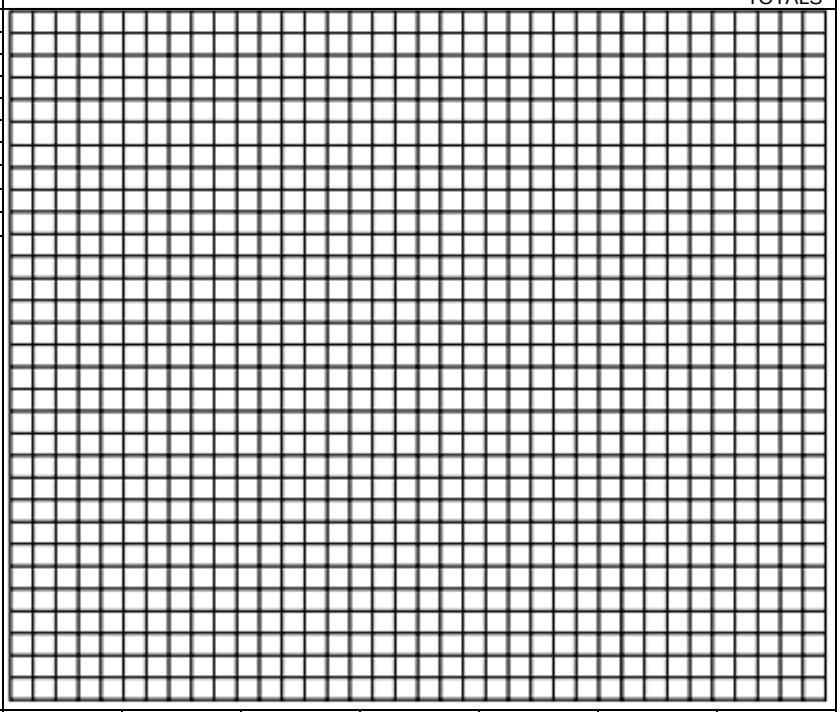
ANESTHESIA RECORD DATE	ANESTHESIA TIME TO	OPERATION TIME TO	NPO POST
ANESTHESIOLOGIST	ANESTHETIST	ASA I ☐ II ☐ III ☐ IV ☐ E ☐	PRE MEDICATION TIME P.O ☐ I.M ☐ I.V ☐

AGENTS

O2 L/M

260
240
ECG 220
SaO2 %
RO2 200
ETCO2
180
160
140
120
100
80
60
BP
Pulse
Resp
40
20
VENT 0
TEMP

TOTALS



TIME REC ROOM	STATUS	BP	P	R	AIRWAY	SACO2	

Machine and Equip. Check ☐

ANES. MACH. NO. _____

Fluid Type _____

I.V: _____ LOC _____Gauge

_____cc

Airway, # _____ Nat./Nasal/Oral

Intubated, # _____ Nasal/Oral

BBS= ☐Difficult ☐Yes ☐No

CUFF= ☐Yes ☐No

☐General ☐Temp ☐PCS
☐Regional ☐BP ☐TOF
☐MAC ☐O2Monitor
☐Pulse Ox ☐VT Monitor
☐EKG ☐ET CO2

Regional Anesthesia
Site _____
Needle _____
Local _____

6A

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POST OP INSTRUCTIONS FOR MINOR SURGERY

1. **Diet**
   - ☐ **Do not drink alcoholic beverages (including beer) for 24 hours. Alcohol enhances the effects of anesthesia and sedation.**
   - ☐ **Progress slowly to your normal diet unless your physician has instructed you otherwise. Begin with liquids and light foods (Jell-O, soups, crackers, etc.) gradually working up to solid foods.**
2. **Medications**
   - ☐ **Use the prescription as directed**
   - ☐ **Rx(s) given to patient:** _____
   - ☐ **Over-the counter: TYLENOL / MOTRIN / ALEVE / ADVIL Use as directed**
3. **Activities**
   - ☐ **Limit your activities for 24 hours. Do not engage in sports, heavy work or heavy lifting.**
   - ☐ **It is highly recommended that a responsible adult stay with you for the next 24 hours.**
   - ☐ **Do not drive or operate hazardous machinery for 24 hours.**
   - ☐ **Do not make important personal or business decision or sign legal documents for 24 hours.**
   - ☐ **When taking pain medication, use caution when you drive, walk or climb stairs. Mild dizziness is not unusual.**
4. **Surgical Site**
   - ☐ **Mild drainage may occur. If dressing becomes saturated with blood, call MD.**
   - ☐ **Do not change your dressing until seen by physician.**
   - ☐ **Keep dressing dry; cover during bathing.**
   - ☐ **Remove dressing / Band-Aid tomorrow.**
   - ☐ **If extremity becomes cold to touch, blue, tingle, numb, or if you have excessive swelling or pain, call MD immediately.**
   - ☐ **If you experience calf pain, redness, swelling or shortness of breath contact your physician immediately. This can be an indication of a deep vein thrombosis (DVT) that would require immediate attention.**
   - ☐ **If you experience signs & symptoms of an infection at operative / IV sites(s) such as a temp of 101F or greater (by mouth), increased pain, swelling, redness, or foul odor, contact MD immediately.**
5. **Follow -Up Care**
   - ☐ **Contact Dr.** _____ **@ Tel:** _____
     Schedule an appointment.

     OTHER INSTRUCTIONS:

     _____

     _____

These discharge instructions have been explained to the patient / significant other. I acknowledge that I understand these instructions. A copy has been given to the patient / significant other.

_____

Physicians Signature / RN Signature Patient / Significant other Signature

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Medication Reconciliation Form

Allergies: NKA_____

List All Medications Including Over the Counter, Dietary Supplements & Herbal Medications						
Medication Name No Medication See attached list	Dose	Route	How Often	Last Dose	Purpose	Comments
Operative Medication:						

New Medication to Take	Dose	Route	How Often	Purpose
Medications to Discontinue:				

NOTE TO PATIENT: Please take this medication list to your next doctor's appointment. It is recommended that you bring your list of current medication to every medical appointment.

Copy of medication reconciliation given to patients? YES NO

_____ _____ _____

Signature of RN obtaining list | Signature of Discharge RN | Patient Signature

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ASSIGNMENT OF BENEFITS & AUTHORIZATION
TO PURSUE APPEAL AND / OR DENIAL OF PIP BENEFITS

[Patient Name]_____

[Insurer]_____

[Claim #]_____

In consideration of the professional services rendered by **PROTECHMED,INC** I, hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and / or arbitrate my claims for PIP insurance benefits regarding the above-captioned claim to Health Care Provider, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims.

2. The authorization of Health Care Provider to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.

3. The authorization of Health Care Provider to initiate and prosecute any and all appeals and / or arbitrations or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer as well as NAF PIP arbitrations.

4. The authorization of Health Care Provider to obtain and / or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.

5. The authorization of Health Care Provider to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and / or the insurer.

6. The authorization for payment of any and all PIP insurance benefits directly to Health Care Provider to which I might be entitled under the above-captioned claim.

_____

Patient Signature: Date:

_____

Witness Signature: Date: