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

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	Clara Clement	PHONE #	347-433-4855	FAX #	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

ereby authorize the following doctor(s): and any such assistants a may be selected by
him/her to perform the following procedure(s) on me:
Left shoulder arthroscopy, rotator cuff/labral repair, partial acromioplasty 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 :tures 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

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 Hawkin's Test __Pos __Neg

Relocation is __Pos __Neg Drop arm test __Pos __Neg

Impingement is __Pos __Neg Arc of pain __Pos __Neg

O'Brien's test __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: _____

Right / Left SHOULDER

CPT CODES (PROCEDURES)

__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 claviculectomy. (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)

ICD-10 CODES (POST-OP DIAG)

__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)
__Chondromalacia (glenoid/hum. head) (R 32, L 33)

Templates

__ 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: