

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.		
Surgeon's Scheduler's Information					
NAME	Clara Clement	PHONE #	347-433-4855	FAX #	929-333-7950
Treating Physical Therapy Office					
NAME	PHONE #	ADDRESS			
Transportation: <input type="checkbox"/> YES <input type="checkbox"/> NO					

Left Knee arthroscopy, meniscectomy, shaving chondroplasty and related 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 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 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 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.

____/____/____ Date _____ Time _____

Physician Signature

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
Ballotment 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: _____

