

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	-		



313 43rd St, Brooklyn, NY 11232

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. Christopher Durant		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 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	PHONE #	FAX #			
Treating Physical Therapy Office					
NAME	PHONE #	ADDRESS			
Transportation: <input checked="" 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)	__ M75.01 Adhesive capsulitis, right shoulder. (10)
__ 29823 Major debridement. (11)	__ M75.02 Adhesive capsulitis, left shoulder. (11)
__ 29822 Minor debridement. (12)	__ S46.101A Biceps tendon tear, right shoulder. (12)
__ 29820 Minor synovectomy. (13)	__ S46.102A Biceps tendon tear, left shoulder. (13)
__ 29821 Complete synovectomy. (14)	__ M75.41 Impingement syndrome, right shoulder. (14)
__ 29819 Loose body removal or fragments. (15)	__ M75.42 Impingement syndrome, left shoulder. (15)
__ 29999 Coblation arthroplasty glenoid. (16)	__ M24.811 Internal derangement, right shoulder. (16)
__ 29824 Distal claviclectomy. (17)	__ M24.812 Internal derangement, left shoulder. (17)
__ 29825 Lysis of adhesions. (18)	__ M75.121 Complete rupture, rot. cuff, rt shoulder. (18)
__ 29999 Bursectomy. (19)	__ M75.122 Complete rupture, rot. cuff, left shoulder. (19)
__ 29826 Decompression, partial acromioplasty. (20)	__ S46.011A Partial rotator cuff tear, right shoulder. (20)
__ 29999 Release of CA ligament. (21)	__ S46.012A Partial rotator cuff tear, left shoulder. (21)
__ 20610 Intraarticular injection. (22)	__ S43.431A Labrum tear, right shoulder. (22)
__ 29827 RC repair arthroscopically. (23)	__ S43.432A Labrum tear, left shoulder. (23)
__ 29807 Slap repair. (24)	__ M65.811 Synovitis, right shoulder. (24)
__ 29806 Bankart repair, capsulorrhaphy. (25)	__ M65.812 Synovitis, left shoulder. (25)
__ 29828 Biceps tenodesis. (26)	__ M75.51 Bursitis, right shoulder. (26)
__ 23770 Manipulation should under anesthesia. (27)	__ M75.52 Bursitis, left shoulder. (27)
__ 23405 Shoulder tenotomy. (28)	__ M24.10 Glenoid chondral defect. (R 28, L 29)
__ 29999 Topaz microdebridement. (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)	__ Anterior Capsular Release (11)
__ Posterior Capsular Release (12)	__ SLAP with no repair (17)
__ Anterior Labrum Bankart tear with no repair (13)	__ SLAP with repair (18)
__ Anterior labral Bankart tear with repair (16)	__ Posterior Labral tear without repair (22)
__ Anterior labral tear, no repair (14)	__ Posterior Labral tear with repair (23)
__ Inferior labral tear, no repair (15)	__ Subscapularis Tear with no repair (24)
__ Biceps tear with debridement (19)	__ Subscapularis Tear with repair, no anchor (25)
__ Biceps tear with tenotomy (20)	__ Subscapularis Tear with repair, with anchor (26)
__ Biceps tear with tenodesis (21)	__ Chondroplasty of the Humeral Head (29)
__ Supraspinatus Tear with no repair (27)	__ Chondroplasty of the Glenoid (30)
__ Infraspinatus Tear with no repair (28)	__ Coblation Arthroplasty of the Glenoid (31)
__ Removal of Loose Bodies (32)	__ Lysis of the Coracoacromial Ligament (36)
__ Subacromial Bursectomy (33)	__ Distal Clavicle Mumford Procedure (37)
__ Subacromial Decompression with Acromioplasty (34)	__ Rotator Cuff tear with no repair (38)
__ Subacromial Decompression without Acromioplasty (35)	__ Rotator Cuff Tear with Repair, 1 anchor (40)
__ Lysis of Adhesions (42)	__ Rotator Cuff Tear with Repair, 2 anchors (41)
__ RC tear with rep. of BioInductive Implant/PLGA Anchor (39)	__ 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: _____