

# Discharge Instructions

# Tonsillectomy

## EndoSoft Surgery Center

135 Broadway

Schenectady, NY 12144

Patient Name: Mary Smith  
Date of Birth: 09/15/1998  
Record Number: 0159876  
Date / Time of Procedure: 2/26/2024, 07:56:49  
Referring Physician: Frank Black, MD  
Surgeon: Debbie Doe, MD

### You have had the following procedure performed:

Tonsillectomy

### Discharged To:

Home

### Prescriptions Given to Patient:

None

### Appointment Information:

Call for an appointment with Dr. Frank Black in 2 weeks.

### Recommendations and Instructions:

#### What to Expect After the Operation:

#### Pain/Discomfort:

Many children have pain for up to 10 to 14 days after surgery.

Ear, jaw and neck pain can occur and may get more severe after 3 to 7 days.

Signs of pain include: crying, touching the head, throat, ears, neck, drooling, refusing to drink.

An ice collar may make your child more comfortable.

It is normal for the uvula in the back of the throat to swell or be very large.

Give the prescribed pain medication Oxycodone and acetaminophen as ordered by your surgeon every 4 hours.

Do NOT give Aspirin products or Ibuprofen (Motrin) products for 2 weeks.

Give pain medication with milk or food to prevent stomach upset.

Encourage frequent chewing to decrease throat, jaw and ear pain.

#### Bleeding:

When the tonsil or adenoid scabs fall off, your child may have bleeding from the mouth or nose.

If you see blood, call ENT immediately.

### EndoSoft, LLC

135 Broadway, Schenectady, NY, 12305

Tel: (518) 831-8000

### Diet/Poor Appetite/Weight Loss:

Encourage your child to drink often, starting the day of surgery. Jell-O, pudding, ice cream and popsicles count as drinks.

Your Tonsillectomy and Adenoideectomy Diary tells you how many ounces your child should drink every day.

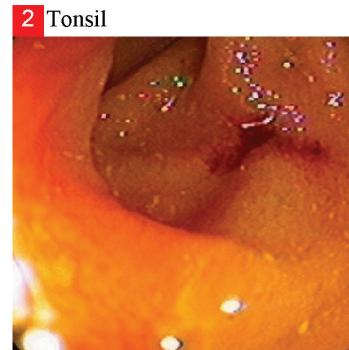
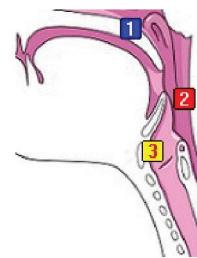
Many children do not want to eat their normal diet for 2 weeks. Appetite will be decreased.

Encourage food and drinks of any kind frequently.

If your child does not want to drink, offer small amounts of fluid often.

Offer Carnation Instant Breakfast or Pediasure if you are concerned with your child's nutrition or weight loss.

There are no food restrictions.



# Procedure Report

# Appendectomy

## EndoSoft Surgery Center

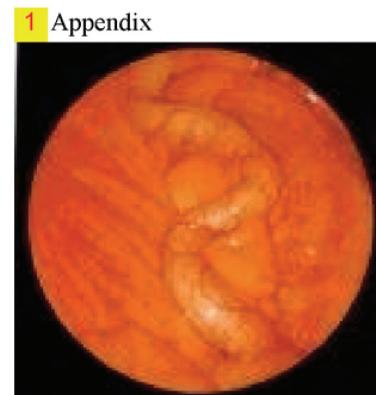
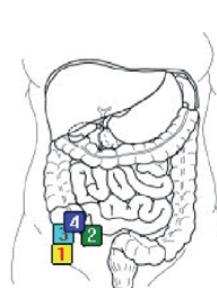
135 Broadway

Schenectady, NY 12144

Patient Name:	Mary Smith
Date of Birth:	09/15/1975
Record Number:	0159876
Date / Time of Procedure:	2/21/2024, 07:56:49
Anesthesiologist:	George Blue, MD
Referring Physician:	Frank Black, MD
Surgeon:	Debbie Doe, MD

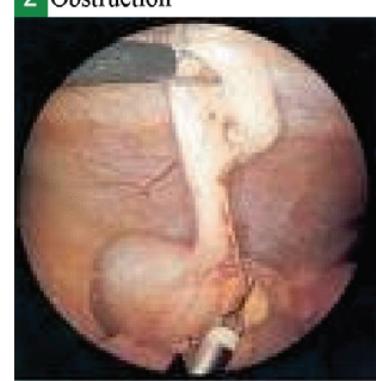
## PROCEDURE PERFORMED:

Appendectomy - laparoscopic appendectomy



## INDICATIONS FOR EXAM:

Acute abdominal pain with guarding in the right lower quadrant for 2 days



## PROCEDURE TECHNIQUE:

Risks and benefits were clearly explained to the patient and the consent form was signed. The patient was brought in the operation room in the supine position. General anesthesia was administered with satisfaction. After the routine prep and drape on the abdomen, a low skin crease incision (Lanz) centered on the McBurney's point was taken as favor of a better cosmetic result. The superficial fascia was then incised and the three musculo-aponeurotic layers of the abdominal wall were split along the line of the fibers. The peritoneum was then lifted and opened and revealed pus/mucopurulent watery fluid; a swab of this is taken for microscopy and culture. The appendix was perforated and located digitally and delivered into the wound. Then, its blood supply in the meso-appendix was divided between clips and ligated. The appendix base was crushed with a haemostat distally, an absorbable ligature was then tied around the crushed area. After this preparation, the appendix was then excised. A "purse-string" suture is usually placed in the cecum near the appendix base, the appendix was inverted and the sutured tied.



As the appendix was perforated and gangrenous and pus was found, a thorough peritoneal toilet was performed. A sump sucker was guided down into the pelvis with a finger to remove any fluid, and the area was gently swabbed with gauze to remove any adherent infected material, then 500 ml normal saline was applied for a thorough lavage. The peritonium, internal oblique and external oblique were each closed with three absorbable sutures. Drainage was not administered as there was no thick-walled abscess cavity.

The patient tolerated the procedure well and was sent to the recovery room safely.



## FINDINGS:

2cm friable, inflamed mucosa in the appendix. Active bleeding noted, Biopsy obtained. Results pending.

## POST SURGERY DIAGNOSIS:

Acute appendicitis

## RECOMMENDATIONS:

As per discharge instructions. Cipro 500 mg x10 days. Clear liquid diet.

Signature: \_\_\_\_\_ Debbie Doe, MD

## ICD 10 Codes:

K35.3 Acute appendicitis with localized peritonitis

## CPT Code:

44970 Laparoscopy, surgical, appendectomy

## EndoSoft Surgery Center

135 Broadway

Schenectady, NY 12144

**Patient Name:** Mary Doe  
**Date of Birth:** 09/15/1950  
**Record Number:** 0159834  
**Date / Time of Procedure:** 02/24/2024, 07:56:49  
**Referring Physician:** Frank Black, MD  
**Surgeon:** Debbie Doe, MD  
**Anesthesiologist:** James Smyths, MD

**PREOPERATIVE DIAGNOSIS:** Complete rupture of rotator cuff.**POSTOPERATIVE DIAGNOSIS:** Complete rupture of rotator cuff.**PROCEDURE PERFORMED:** Shoulder rotator cuff repair.**ALLERGIES:** None**INDICATIONS FOR EXAMINATION:** Shoulder pain refractory to conservative pain treatment.**PATIENT POSITION:** Modified beach chair position.**EXAMINATION UNDER ANESTHESIA:** Full range of motion.

**PROCEDURE TECHNIQUE:** Risks and benefits were clearly explained to the patient and the consent form was signed. The patient was put in the modified beach chair position with the shoulder site well exposed and the landmarks of clavicle head, acromion were marked for procedure orientation.

After the patient was prepped, draped and anesthesia satisfied (regional block + general anesthesia), the ports were positioned at back and up, size at 6mm each; normal saline in-filled to distend the space for vision, arthroscope inserted through the back port.

The attention was focused on the glenoid humeral joint, SLAP lesions: the superior labral was found partially detached from the bone and partial SLAP tear was found at the very front of the shoulder, the socket was stable, the long head of the biceps tendon was healthy but there was a bit of fraying of the rotator cuff but not significant damage.

The shaver was applied to remove some of the frayed and degenerative-looking tissue at the very top of the shoulder and then cleaned up some of the soft tissue near the boney attachment where the labral was supposed to be attached to. Holes were drilled on the bone and anchors were used for attachment of the detached labral socket, nice and stable to the bone.

Next, the attention was on the upper rotator ruff area and AC joint: subacromial space: the bursa was found inflamed and thickened with a reddish appearance followed by a clearing out of the frayed soft tissue for a clear view of the acromion; a great big spurs were demonstrated followed by power burr used to remove the bone spur. Meantime a suction on the hand piece to remove the bone debris yielding the acromion a nice, flat smooth structure from all different perspectives. The decompression was done.

There was not any articular cartilage remaining on the AC joint. A large sized bicep tendon tear was noticed, but not appearing to be terribly retracted. The inflamed bursa tissue was removed to expose the proximal humerus, and the greater tuberosity where the rotator cuff, followed by a double row fixation applied for the repair. The clavicle was with arthritis changes of spur and the spur was reamed with same too burr, 1-1.2 cm was resected and thus space expanded.

Dressing routinely and the operation was done without complications.

**FINDINGS:** At the glenoid humeral joint the superior labral was found partially detached from the bone and partial SLAP tear was found at the very front of the shoulder, the socket was stable, the long head of the biceps tendon was healthy but there was a bit of fraying of the rotator cuff but not significant damage. The long head of biceps tendon looks healthy, at the rotator cuff area and the AC joint, the subacromial space bursitis was detected.

Signature: \_\_\_\_\_ Debbie Doe, MD

**ICD 10 Codes:** M75.120 Complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic

**CPT Code:** 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair.



PATIENT NAME: DOE JANE A  
DATE OF BIRTH: 02-Dec-1976  
RECORD NUMBER: 12  
DATE/TIME OF PROCEDURE: 08-Jan-2018 / 14:22:07  
ENDOSCOPIST: ALBERT COHEN,  
REFERRING PHYSICIAN:

#### PROCEDURE PERFORMED

Colonoscopy

#### INDICATIONS FOR EXAMINATION

Surveillance.

#### TISSUE SUBMITTED

Jar 1 - biopsy from the mid ascending colon r/o adenoma.  
Jar 2 - biopsy from the mid transverse colon r/o adenoma.  
Jar 3 - biopsy from the mid descending colon r/o adenoma.

#### FINDINGS

9 cm sessile polyp in the mid ascending colon. Polypectomy performed with cold snare.  
3 cm sessile polyp in the mid transverse colon. Polypectomy performed with cold snare.  
5 cm sessile polyp in the mid descending colon. Polypectomy performed with cold snare.

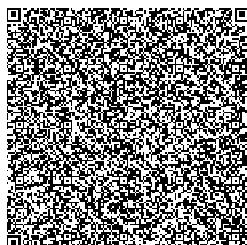
#### POST OPERATIVE IMPRESSION

Colon Polyps

#### RECOMMENDATIONS

Repeat colonoscopy in 5 years.  
Return to the office in one week to follow up after biopsy results.  
Refrain from driving (or operating heavy machinery) until the day after your colonoscopy.  
Unless otherwise instructed, resume normal activity including eating and drinking.  
Avoid drinking alcohol for 24hrs after your Colonoscopy.  
Immediately call my office on 518-831-8000 if you experience Fever, Chills, Rectal Bleeding, Swelling of the IV Site, Severe Abdominal Pain or Bloating within 24hrs of your Colonoscopy.

Pathology Requisition



Tissue(s) Submitted



# Procedure Report

# Cystoscopy

**EndoSoft Surgery Center**  
135 Broadway  
Schenectady, NY 12144

**Patient Name:** Mike Smith  
**Patient Sex:** Male  
**Date of Birth:** 09/15/1952  
**Record Number:** 0159876  
**Date / Time of Procedure:** 2/23/2024, 07:56:49  
**Referring Physician:** Frank Black, MD  
**Surgeon:** Debbie Doe, MD

## PROCEDURE PERFORMED:

Cystoscopy - Cystourethroscopy

## INDICATIONS FOR EXAM:

Hematuria

**Instruments:** 2000778 TF140F  
**Medications:** None  
**Extent of Exam:** Right Ureter  
**Limitations:** None

## PROCEDURE TECHNIQUE:

A physical exam was performed. Informed consent was obtained from the patient after explaining all the risks (perforation, bleeding, infection and adverse effects to the medicine), benefits and alternatives. The patient understood and so stated. The patient was connected to the monitoring devices and placed in the dorsal lithotomy position, prepared and draped. A 8Fr red rubber catheter was inserted into the bladder, residual urine was: 42 cc's. A 7Fr dual-lumen cystometrogram catheter was introduced under direct vision and connected to a OM-5 urodynamic machine. Using sterile water, at a flow rate of 66 cc's / min, the bladder was filled to capacity. The first urge to urinate occurred at a volume of: 103 cc's with a capacity of: 310 cc's.

A leak-point pressure was performed by asking the patient to cough at a volume of 9cm H<sub>2</sub>O. After removing the catheter, the patient was placed under conscious sedation by the anaesthesiologist. A Cystoscopy was performed using 2000778 TF140F and the Cystoscope was introduced into the urethra and bladder. A thorough examination was performed. Using sterile water, the bladder was filled via gravity to capacity, while under anaesthesia. The patient was subsequently transferred to the recovery area in satisfactory condition. The following findings were noted:

## FINDINGS:

Friable 2 cm prostate weighing 17g. Lateral Lobes: inflamed. Biopsy obtained, results pending.

## POST PROCEDURE DIAGNOSIS:

Hematuria.

## RECOMMENDATIONS:

Cystourethroscopy in 6 months.

Signature: \_\_\_\_\_ Debbie Doe, MD

## CPT Code:

52000 Cystourethroscopy (Sep Proc)

## ICD 10 Codes:

R31.0 Gross Hematuria



1 Prostate

2 Prostate

3 Prostate

# Procedure Report

# Bronchoscopy



## EndoSoft Surgery Center

135 Broadway

Schenectady, NY 12144

Patient Name: Robert Smith  
Date of Birth: 09/15/1950  
Record Number: 0159834  
Date / Time of Procedure: 5/18/2024, 07:56:49  
Referring Physician: Frank Black, MD  
Pulmonologist: Debbie Doe, MD

**PROCEDURE PERFORMED:** Flexibility bronchoscopy

**INDICATIONS FOR EXAMINATION:** Large airway obstruction in the left main stem for one month.

**INSTRUMENTS:** Loaner  
**MEDICATIONS:** Demerol 25 mg, Versed 1 mg  
**VISUALIZATION:** Good    **TOLERANCE:** Good    **COMPLICATIONS:** None  
**EXTENT OF EXAM:** All segments visualized to subsegmental  
**LIMITATIONS:** None

**PROCEDURE TECHNIQUE:** Flexible bronchoscopy: A physical exam was performed and an informed consent was obtained from the patient after explaining the risks, (pneumothorax, life threatening bleeding, infection and adverse effects due to medications) benefits and alternatives to the procedure which the patient appeared to understand and so stated. The patient was connected to the monitoring devices. Continuous oxygen was provided with a nasal cannula and IV medicine administered through an indwelling IV catheter. Lidocaine 2%, viscous lidocaine, Demerol 25 mg, Versed 1 mg were used for local anesthesia and conscious sedation. The bronchoscope was inserted and the airway examined.

**FINDINGS:** Extrinsic compression stricture begins left mainstem bronchus to the left lower lobe extending for the length of 3cm. Scope could be advanced beyond the stricture. The estimated diameter of the lumen was 8mm.

Simple weblike stricture begins LUL entrance with 70% stenosis. Scope could not be advanced beyond the stricture. The estimated diameter of the lumen was 4mm. This was estimated using the scope diameter comparison technique. Diffuse erythema and friable tissue submucosal inflammation was located in the LUL entrance with 80% stenosis.

**PULMONOLOGIST DIAGNOSIS:** Malignancy, primary lung, small cell in left main stem. Benign stricture, radiation fibrosis in the LUL entrance. Small cell carcinoma of the lung.

## RECOMMENDATIONS:

Follow-up with your Primary Care provider in 2 weeks

Signature: \_\_\_\_\_ Debbie Doe, MD

## ICD 10 Codes:

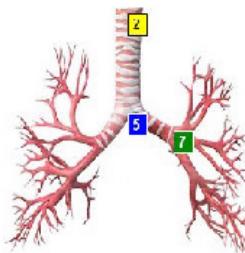
C34.80 Malignant neoplasm of overlapping sites of unspecified bronchus and lung

## CPT Code:

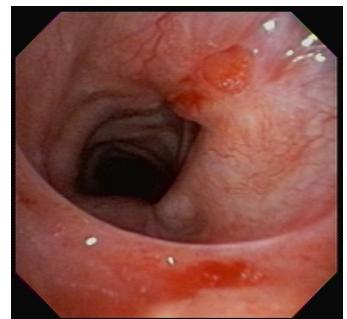
31622 Bronchoscopy

## G Codes:

G8907



1 Right Lower Lobe Entrance



2 Left Mainstem



3 Left Lower Lobe



4 Left Upper Lobe

