Outpatient Assessment/History and Physical

Date: ____/____/____ **Patient Name:**_____ **Eye(s):** OS / OU / OD

Diagnosis and indications for surgery:❑Cataract ❑Other: _____

Procedure planned:❑Cataract removal with intraocular lens implant ❑Other: _____

Medications taken on a regular basis: _____

Is the patient on an anticoagulant?❑Coumadin ❑Plavix ❑Aspirin ❑NSAID ❑Other:_____

Does the patient smoke?❑Yes ❑No **Number of years:**_____ **Number packs/day**:_____

Currently taking any of the following: ❑Flomax/Tamsulosin❑Doxazosin❑Uroxatral❑Rapaflo

Allergic to: Latex ❑Yes **Betadine** ❑Yes **Codeine** ❑Yes **Eggs** ❑Yes **Sulfa** ❑Yes

Other allergies or sensitivities to any foods or medications (indicate reaction): _____

_____

Past Medical History: *(Please explain all Yes answers)*

Asthma / COPD	❑Yes	❑No
Diabetes	❑Yes	❑No
Heart Disease	❑Yes	❑No
Hypertension	❑Yes	❑No
Seizures	❑Yes	❑No
Peptic Ulcers	❑Yes	❑No
BPH Stroke	❑Yes	❑No

Explanation of Yes answers: _____

_____

_____

Physical Exam:

Alert & Oriented x 3	❑Yes	❑No
ENT Normal	❑Yes	❑No
Chest Clear to Auscultation	❑Yes	❑No
Heart Sounds Normal	❑Yes	❑No
Abd Soft Without Tenderness	❑Yes	❑No
Neurological Grossly Intact	❑Yes	❑No

Lab Findings: _____

_____

_____

Physician Notes: _____

_____

Patient cleared for surgery: ❑Yes ❑No

_____ _____

Examining Physician Signature: Date

Pre-Operative Questionnaire

Patient's Name_____ **Date of Surgery**_____

Gender: M/F **Ethnicity:** _____ **Operative Eye:**_____**Height** _____**Weight** _____

1. Do you have a current or chronic illness? ❑ Yes ❑ No
If Yes, explain: _____

2. Have you ever had a bad reaction to anesthesia? ❑ Yes ❑ No
If Yes, what and when:_____

3. Is there any possibility you could be pregnant? ❑ Yes ❑ No

4. Have you been diagnosed with BPH (Benign Prostatic Hyperplasia)? Are you your currently Flomax/Tamsulosin or Doxazosin, Uroxatral, Rapaflo? ❑ Yes ❑ No

5. Are you allergic to: **Latex**❑Yes **Betadine**❑Yes **Codeine**❑Yes **Eggs**❑Yes **Sulfa**❑Yes
If Yes, describe reaction:_____

6. Are you allergic or sensitive to any foods, medications or other?❑ Yes ❑ No
If Yes, what and describe reaction:_____

7. What medications are you taking? List name, amount, how often, and the reason for taking medication.

Drug/Amount	How Often	Reason

8. Have you ever had:

Heart Disease	❑Yes ❑ No	**High Blood Pressure**	❑Yes ❑ No	**Asthma**	❑Yes ❑ No
Rheumatic Fever	❑Yes ❑ No	**Tuberculosis**	❑Yes ❑ No	**Diabetes**	❑Yes ❑ No
Heart Attack	❑ Yes ❑ No	**Kidney Disease**	❑Yes ❑ No	**Jaundice**	❑Yes ❑ No
Chest Pain	❑Yes ❑ No	**Bleeding Problems**	❑Yes ❑ No	**Ulcers**	❑Yes ❑ No
Stroke	❑Yes ❑ No	**Seizures**	❑Yes ❑ No	**Back Trouble**	❑Yes ❑ No
HIV/AIDS	❑Yes ❑ No	**Hepatitis**	❑Yes ❑ No	**Cancer**	❑Yes ❑ No
Sleep Apnea	❑Yes ❑ No	**Glaucoma**	❑Yes ❑ No	**Mental Illness**	❑Yes ❑ No

If Yes, did you receive any treatment? Describe:_____

_____

9. Are you currently taking any anticoagulants (Aspirin, Coumadin, Plavix, etc.)? ❑ Yes ❑ No

10. Do you tend to bleed easily? ❑ Yes ❑ No

11. Do you smoke? ❑ Yes ❑ No If Yes, for how long?_____How much?_____

12. Do you use alcohol? ❑ Yes ❑ No If Yes, how much? _____ How often? _____

13. Do you have any dentures? ❑ Yes ❑ No

14. Do you currently have a pacemaker? ❑ Yes ❑ No

15. Do you have any medical condition that you feel your Anesthesiologist should know about?____

Questionnaire completed by_____ **Relationship to patient**_____

Palisades Eye Surgery Center 4831 Cordell Avenue● Bethesda MD 20814●Phone:301-657-8200● Fax: 301-657-4121

PATIENT RIGHTS AND NOTIFICATION OF PHYSICIAN OWNERSHIP

You will be undergoing a procedure in our facility, and we would like to inform you of your rights.

SUBMISSION AND INVESTIGATION OF GRIEVANCES: You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision. The following are the names and/or agencies you may contact:

Kristin Price , Nurse Manager/Center Director
Palisades Eye Surgery Center
4818 Del Ray Avenue
Bethesda, MD 20814
Tel 301-657-8200

MARYLAND REGULATORY AGENCY: To Download a Form go to: www.dhmh.state.md.us/ohcq/complaint/complaint.htm.

Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228
800-492-6005

Sites for address and phone numbers of regulatory agencies:
Medicare Ombudsman website: www.medicare.gov/Ombudsman/resources.asp
Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)
Office of the Inspector General: http://oig.hhs.gov
Department of Health and Mental Hygiene: If you have a complaint- www.dhmh.maryland.gov/ohcq

RIGHTS AND RESPECT FOR PROPERTY AND PERSON
The patient has the right to: Exercise his or her rights without being subjected to discrimination or reprisal; Voice grievance regarding treatment or care that is or fails to be furnished; Be fully informed about a treatment or procedure and the expected outcome before it is performed; Confidentiality of personal medical information

PRIVACY AND SAFETY
The patient has the right to: Personal privacy; Receive care in a safe setting; be free from all forms of abuse or harassment

ADVANCE DIRECTIVES
You have the right to information on the Center's policy regarding Advance Directives. Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. If you request, an official state Advance Directive Form will be provided to you.

PHYSICIAN FINANCIAL INTEREST AND OWNERSHIP
The Center is owned by physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

❑ **If I am signing on the day of surgery, I certify that I have been given an opportunity to read this form prior to the day of surgery.**

X _____

Physician Contact List

Signature of Patient or Patient Legal Representative Printed Name Date

Pre-Operative Call

Date of surgery: _____ **Time to arrive**: _____

1. Medication to take morning of surgery: BP/Cardiac Medications
2. Medication to omit morning of surgery: Diabetic Medications (Do NOT take oral diabetic medications in the morning and bring your insulin with you to the surgery center)
3. NPO solids after midnight. May drink clear liquids up to two hours prior to surgery. Clear liquids include only the following; water, apple juice, cranberry juice, carbonated soda or water, tea, or coffee. May include sugar in coffee. NO DAIRY PRODUCTS such as cream or milk in tea or coffee.

Reminders

- ❑ Complete and bring Pre-Operative Questionnaire
- ❑ Driver to accompany to/from surgery center: phone no. _____
- ❑ No driving for 24 hours after surgery
- ❑ Bring medication, eye pack and sunglasses along to the surgery center (Pluznik, Green-Simms, Fischer, Gupta, and Frank bring packs) (Moshedi has packs at the Center)
- ❑ Please use the red top, Tropicamide dilating drop to dilate your eyes prior to surgery. Instill one drop 2 hours before surgery and another drop every 30 minutes in the operative eye. (Patients only dilate for cataract cases. NO dilation for glaucoma or plastic cases).
- ❑ Bring copy of Advance Directive or Living Will if available.
- ❑ Wear loose fitting clothing (a short sleeve shirt is a MUST per Dr. Moneta to allow access for the blood pressure cuff and IV access) and leave jewelry and valuables at home.
- ❑ Bring Insurance cards and photo ID
- ❑ Bring money for parking. (We pay for up to 2 hours ONLY in the attached garage.) Please allow extra time for parking due to nearby construction
- ❑ Spoke with patient
- ❑ LM on voicemail

Signature: _____ Date: _____