

Surgical Precertification

Patient: _____ **Surgery Date:** ____/____/____

Anesthesia: MAC Gen Local w/Pop. Pain Pump **Length:** _____Min Hours

Location: BNHC ECH EMP Joe/James Brom. **Position:** Supine Prone Lateral

Surgical Procedures: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Special Needs: Fluroscopy Mini/Small/Large Frag. Cannulated/Vilex
 Pain pump Orthosorb Pins Graftjacket/Pegasus

Other: _____

Bring: ___Short Boot ___Tall Boot ___Aircast ___Surgical Shoe

Date Called: ____/____/____ Contact Name: _____

Coverage in Effect? Yes No

Deductible? Yes No Reset Date: ____/____/____

Amount: \$_____ Amount Met to Date: \$_____

Copay/Coinsurance? Yes No Amount? _____

Policy Limits? _____

H&P by Dr. _____ Scheduled: ____/____/____

Consent Done? Yes No

Faxed

Faxed

Schedule ____/____/____

Labs ____/____/____

H&P ____/____/____

History ____/____/____

Post-Op Call ____/____/____

Notes: _____

Initials: _____



DR. SCOTT O'CONNOR

Fellow, American College of Foot & Ankle Surgery
Diplomate, American Board of Podiatric Surgeons
Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

Normal – (309) 807-0384

Pontiac – (815) 842-6551

Eureka – (309) 467-2371

ACKNOWLEDGEMENT OF INFORMED CONSENT TO OPERATION OR PROCEDURE

1. I hereby request and authorize Dr. O'Connor and such assistants he/she might select to treat the condition(s) which appear indicated. The proposed procedure to treat my condition is

_____. Initial_____

2. My doctor has explained to me the diagnosis of my condition and the nature and purpose of the procedure for which this consent is given, as well as the risks and complications associated with this procedure to include, but not limited to, **numbness, delayed healing, continued pain, prolonged swelling, recurrence of deformity, infection of tissue or bone, scar tissue, worsening or no improvement of deformity, loss of length or range of motion, nerve entrapment, RSD (painful nerve disorder), further surgery, reaction to materials, or blood clot.** In addition, he/she has advised me of the feasible alternative forms of treatment including modification of activity or shoe gear, padding, anti-inflammatories, injection, or nothing.

Initial_____

3. I am aware that during the course of the authorized procedure, expected conditions may be revealed that require an extension of the authorized procedure or performance of a procedure different than stated in paragraph #1. I, therefore, authorize the above named physician and selected assistant(s) to perform such surgical and/or medical procedures as necessary in his/her professional judgment. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure(s).

Initial_____

4. Where anesthesia services may be required as part of this operation or procedure, I have been advised and acknowledge that I am aware that there are risks and complications involved in the administration of anesthesia. The complications may include nausea, vomiting, chest problems, or more serious risks associated with anesthesia. When airways are used, there may be soreness of the throat with increased sputum and coughing; and there may be damage to decayed or loose teeth, porcelain caps or bridgework. I consent to the administration of anesthesia.

Initial_____

5. Any organs, tissues, or members of my body removed during the course of the procedure may be examined or disposed of in accordance with accustomed practice and regulations.

Initial_____

6. Circle one: (I do), (I do not), consent to the presence of observers, approved by the attending surgeon/physician, during the course of the procedure for the purpose of advancing health education.

Initial_____

Signature of Patient or Authorized Person

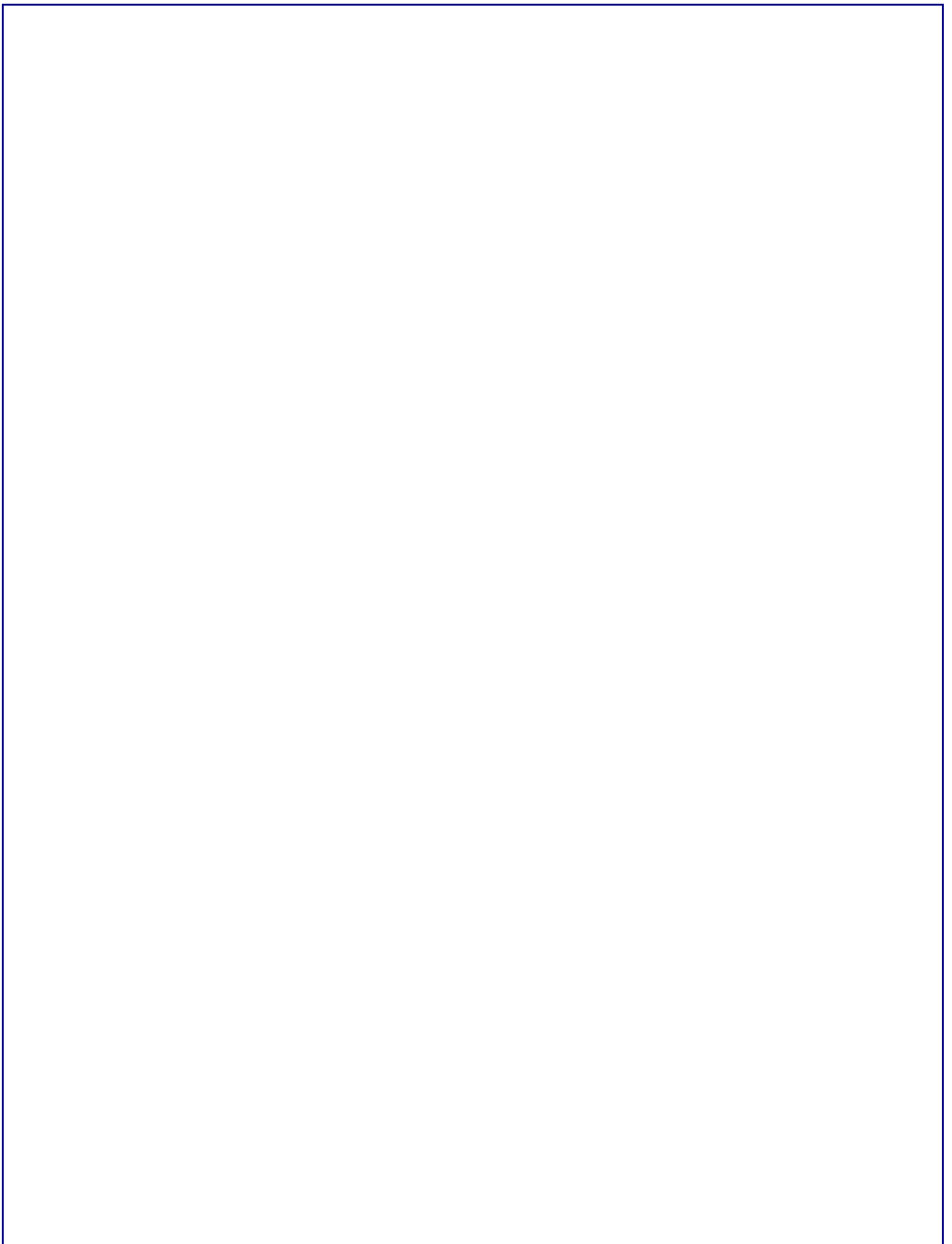
Relationship

Date

Signature of Doctor

Witness

Date



Central Illinois Foot & Ankle Center Surgical Superbill

4047-F(abx ordered)		4041-F(ancef)		4041-F/1P9(not ancef)		Pain Pump-A4306	
<u>Amputations</u>		<u>Capsulotomy</u>		<u>Forefoot Surgery</u>		<u>Rearfoot Surgery</u>	
28825	IPJ L/R/B	28272	IPJ (flexor set) L/R/B	28122	Tarsal/Metatarsal L/R/B	28008	Plantar Fasciotomy L/R/B
28810	Met + Toes L/R/B	28264	Midtarsal (HHS) L/R/B	28114	Panmet Resection L/R/B	29893	EPF L/R/B
28820	MPJ L/R/B	28270	MPJ L/R/B	28288	Planter Condylectomy L/R/B	00020T	ESWT L/R/B
28805	Transmet L/R/B	<u>Debridement</u>		28308	Lesser Met/DMO/Mini L/R/B	28119	Heel Spur L/R/B
<u>Arthrodesis</u>		11042	SubQ L/R/B	28315	Sesamoidectomy L/R/B	28118	Calcaneus (Haglunds) L/R/B
28740	Mid/tarsomet-single L/R/B	11043	Deep L/R/B	28111	Methead-1st L/R/B	28070	Sinus Tarsi L/R/B
28750	MPJ L/R/B	11044	Bone L/R/B	28112	-2-4 L/R/B	28300	Calc(Dwyer, MDO) L/R/B
28725	Subtalar/MBA L/R/B	<u>Wart/Biopsy</u>		28113	-5th L/R/B	28250	Steindler Stripping L/R/B
28715	Triple L/R/B	11100	Biopsy Skin L/R/B	28309	Multiple Met-Lepird L/R/B	27685	TAL (Hoke, Z) L/R/B
27870	Ankle L/R/B	17111	Co2 Laser Excision L/R/B	<u>Midfoot Surgery</u>		27630	Tenosynovectomy L/R/B
28730	Multiple Mid/TM L/R/B	<u>Digit</u>		28238	Kidner L/R/B	<u>Removal</u>	
<u>Ankle</u>		28285	Arthroplasy L/R/B	28304	Midtarsal (Cole, Metad) L/R/B	28193	Foreign Body-comp. L/R/B
29898	Extensive Debride L/R/B	28150	Phalangectomy L/R/B	28305	-with autograft L/R/B	28192	-deep L/R/B
29897	Limited Debride L/R/B	28755	IPJ Fusion L/R/B	<u>Nail</u>		20680	Removal Fixation L/R/B
29894	Removal Loose Body L/R/B	28124	Toe/Tripsy L/R/B	11730	Avulsion Nail L/R/B	<u>Repair</u>	
27620	Arthrotomy-explore L/R/B	28234	Extensor Tenotomy L/R/B	11732	-each additional L/R/B	27650	Achilles Tendon L/R/B
27625	-w/synovectomy L/R/B	28280	Syndactylism L/R/B	11750	Nail + Matrix (P&A) L/R/B	27654	Secondary Achilles L/R/B
27626	-w/tenosynovec. L/R/B	28760	Jones Fusion L/R/B	<u>Nerve</u>		27695	Primary of collateral L/R/B
28120	Talus/Os Trigonum L/R/B	<u>Excision</u>		28080	Morton Neuroma L/R/B	27698	Secondary LAS L/R/B
28890	ESWT L/R/B	11421	Benign Lesion <1.0cm L/R/B	64782	Other foot Neuroma L/R/B	27658	Flexor of leg L/R/B
<u>Bunionectomy</u>		11422	1.1-2.0 cm L/R/B	28035	Tarsal Tunnel L/R/B	20220	Bone Biopsy L/R/B
28310	Akin L/R/B	11423	2.1-3.0 cm L/R/B	<u>Open Reduction</u>		20900	Bone Graft L/R/B
28299	Double Osteotomy L/R/B	11424	3.1-4.0 cm L/R/B	28415	Calcaneus L/R/B	<u>Non-Surgical</u>	
28296	Austin L/R/B	28104	Bone Cyst (other) L/R/B	28505	Hallux L/R/B	76000	Fluoroscopy L/R/B
28292	Modified McBride L/R/B	28100	Bone Cyst-talus L/R/B	28525	Lesser Toe L/R/B	L-4360	Pneumatic Boot L/R/B
28110	Tailors Bunion L/R/B	28090	Ganglionic Cyst L/R/B	28485	Metatarsal L/R/B	L-4386	Non-Pneumatic L/R/B
28293	Joint w/ Implant L/R/B	28045	Mass/Tumor-subq L/R/B	28531	Sesamoid L/R/B	L3260	Surgical Shoe L/R/B
28297	Lapidus L/R/B	28039	Mass-subq >1.5 cm L/R/B	28445	Talus L/R/B	20550	Injection Trigger Point L/R/B
28289	Cheilectomy L/R/B	28043	Mass-deep <1.5 cm L/R/B	27792	Ankle-fib only L/R/B	20605	Injection Joint-medium L/R/B
28306	CBWO/Scarf L/R/B	28060	Partial Fasciectomy L/R/B	28465	Tarsal L/R/B	20605	Injection Joint-medium L/R/B

Name

Scheduling Superbill

682.7	Abcess Foot	825.0	Fracture-Calcaneus	355.6	Neuroma	845.01	Sprain-Deltoid
681.1	Abcess Toe	825.23	-Cuboid	733.82	Non-Union Fracture	845.03	-Tib/Fib ligament
718.87	Ankle Instability	825.24	-Cuneiforms	703	Onychocryptosis	845.12	-Foot MPJ
216.7	Benign Lesion	825.25	-Metatarsal	703.8	Onychodystrophy	733.94	Stress Fracture-met.
917.3	Blister-w/ infection	826.0	-Toe	110.1	Onychomycosis	733.99	-other
733.21	Bone Cyst	727.41	Ganglion-Joint	715.17	Osteoarthritis	997.61	Stump Neuroma
726.91	Bone Spur	727.42	-Tendon sheath	730.07	Osteomyelitis-acute	729.81	
727.3	Bursitis	785.4	Gangrene	730.17	-chronic	727.1	Tailors Bunion
726.73	Calcaneal Spur	274.03	Gout-Chronic w/tophi	681.11	Paronychia	754.62	Talipes-Calcaneovalgus
726.9	Capsulitis/Tendonitis	732.6	Haglunds Deformity	443.9	PVD	754.59	-Calcaneovarus
736.73	Cavus Foot	735.8	Hallux Interphalangeus	754.61	Pes Planus	754.71	-Cavus
754.91	Clubfoot	735.3	Hallux Malleus	728.71	Plantar Fasciitis/Fibroma	754.51	-Equinovarus
755.67	Coalition-tarsal/calc.	735.2	Hallux Rigidus	736.70	Plantarflexed Metatarsal	754.60	-Valgus
250.00	Diabetes w/o comp.	735.0	Hallux Valgus	757.39	Porokeratosis	355.5	Tarsal Tunnel
250.60	-Neuropathy	735.1	Hallux Varus	736.79	Pronation	726.71	Tendonitis-Achilles
250.70	-Circulation	735.4	Hammertoe	696.00	Psoriatic Arthropathy	727.79	-Peroneal
726.7	Enthesiopathy-Ankle	701.1	Hypertrophic Scar	443.00	Raynaud's Syndrome	726.72	-Tibialis
736.72	Equinus	996.67	Infection/Inflam Rxn	714.00	Rheumatoid Arthritis	727.06	Tenosynovitis
726.91	Exostosis	959.70	Injury-Foot/Ankle	727.67	Rupture-Achilles	707.0	Ulcer-Decubitus
709.4	Foreign Body Granuloma	719.07	Joint Effusion	727.68	-other tendon	707.13	-Ankle
824.2	Fracture-Lateral Mall.	755.65	Macroducty Toes	733.99	Sesamoiditis	707.14	-Heel/Midfoot
824.0	-Medial Mall.	754.53	Metadductus	239.2	Soft Tissue Mass	707.15	-Other part foot
825.21	-Talus	726.7	Metatarsalgia	845.09	Sprain-Achilles	.078.19	Verruca Plantaris
825.22	-Navicular	754.52	Met. Primus Varus	845.02	-Ankle Ligament	996.49	Wire,Pin Pain

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						29515	Ap of Splint L/R/B

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		845.12 -Foot MPJ
		733.94 Stress Fracture-met.
		733.99 -other
		997.61 Stump Neuroma
		729.81
		727.1 Tailors Bunion
		754.62 Talipes-Calcaneovalgus
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		726.72 -Tibialis
		727.06 Tenosynovitis
		707.0 Ulcer-Decubitus
		707.13 -Ankle
		707.14 -Heel/Midfoot
		707.15 -Other part foot
		.078.19 Verruca Plantaris
		996.49 Wire,Pin Pain

BNHC Fort Jesse Surgery Center Scheduling Information

Patient Information:

Last Name: _____ First Name: _____ M.I. _____
Date of Birth: ___/___/___ Gender: M / F SSN: _____
Home Phone#: _____ Work Phone#: _____ ext. _____

Surgery Information:

Date: ___/___/___ Time: _____ Duration and/or Case #: _____
Primary Insurance: _____ Policy #: _____ Group #: _____
Insurance Pre-Certification Phone# _____ Anesthesia Type: _____
Diagnosis: _____

Comments: _____

Procedure(s): _____

Physician: _____

More Patient Information:

1. Drivers License #: _____

Any other significant personal info such as: maiden name, race, religion, language, ect... _____

2. Employment: Occupation (job title) _____

FT/PT/other _____ Student Status: FT/PT/Non-student

Employer Address/Phone# _____

3. Patient Address: (home and/or mailing)

4. Related Party Insurance: Self Responsible? Yes/No If No, fill out below:

Name: _____ D.O.B. ___/___/___ Gender: M / F

Address: _____

Phone #: _____ SSN: _____

Relationship to Patient: _____

Employment date effective: ___/___/___

Occupation : _____ Work Phone#: _____

Address: _____

Payer Name: _____

Faxed/Sent by: _____

Date: ___/___/___ Time: _____

**BLOOMINGTON / NORMAL HEALTHCARE
SURGERY CENTER
PRE-ANESTHESIA/ SURGERY QUESTIONNAIRE**

Date of Surgery: _____
 Name: _____ Birth Date: _____ Actual Weight: _____
 Surgeon: _____ Age: _____ Height: _____

1. Allergies (Include medications, foods, environment, balloons, and/or latex allergies). Name and describe reactions.
 If no allergies, check here.

2. Any Previous Surgeries (List type and year). _____

Have you ever had a problem with an anesthetic? Yes No
 If yes, what happened? _____

Has anyone in your family ever had a problem with an anesthetic? Yes No
 If yes, what happened? _____

3. Have you had within the last month, any of the following?

	Yes	No		Yes	No
Cold	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Flu	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Congested Cough	<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, explain: _____

4. Do you use tobacco? Yes No Quit When? _____
 What? _____ Packs per day? _____ How many years? _____
 Do you drink alcohol? Yes No
 If yes, amount per day? _____ Week? _____ Month? _____
 Do you use street drugs? Yes No
 If yes, drug name: _____ Last used: _____

5. Check any of the following that you have:
 Glasses Contact Lens Hearing aid: L R
 Dentures: Upper Lower Capped Teeth Partial / Bridge: Upper Lower
 Walker Cane Crutches Wheelchair
 Prosthesis: _____ Implants: _____

6. Are there any religious or cultural practices that the staff needs to be aware of while here?
 Yes No If yes, list: _____

7. Do you follow a certain diet at home? Yes No If yes, please explain: _____

8. Answer if patient is 16 or under:
 Is there any developmental delay? Yes No If yes, explain: _____
 Childhood immunizations up to date? Yes No If no, explain: _____
 Was child born on at: Full term Premature by: _____ weeks

9. Do you have a medical history of (please check in appropriate column):

	Yes	No	Comments		Yes	No	Comments
Heart Attack (Date)				Bowel Problems			
Mitral Valve Prolapse/Murmur				Back Problems/ Back Pain			
Shoulder/Arm Pain				Arthritis			
Chest Pain				Meningitis			
Irregular Heart Beat				Cerebral Palsy			
Fast Heart Rate				Multiple Sclerosis			
Congestive Heart Failure				Seizure Disorder			
High Blood Pressure				Epilepsy			
Rheumatic Fever				Motion Sickness			
Pacemaker				Headache			
Sleep Apnea/CPAP				Parkinson's			
Shortness of Breath				Stroke (Date)			
Asthma				Myasthenia Gravis			
Emphysema				Depression			
Bronchitis				Anxiety			
Hay Fever				Mental Disorder			
Tuberculosis				Bleeding Disorder			
Chronic Cough				Diabetes			
Ulcers				Glaucoma			
Liver Disease				Thyroid Problem (Low/High)			
Jaundice/Hepatitis				Skin Conditions			
GERD				AIDS/HIV			
Hiatal Hernia				Cancer (Type)			
Kidney Disease				Treatment:			
Kidney Stone				Carrier Infectious Disease			
Dialysis				Are you pregnant?			
Frequent Urination				Last Menstrual Period: Date:			
Incontinence				Mental or Physical Handicaps:			
Prostate Problems				Other:			

10. Medications: List all medications, dosage and frequency that you currently take below: (Include prescription, non-prescription drugs, and herbals)

If taking no medications, check here

Surgicenter Use Only Below

Surgical Procedure: _____ Date: _____ Reviewed By: _____
 Pre-op Phone Call: No Health Changes _____ RN Signature _____ Date _____

The risks, benefits and plan for anesthesia have been discussed with the patient

Anesthesia Notes:

Airway: _____

Heart: WNL _____ Other _____

Lungs: Clear to Auscultation _____ Other _____

EKG: WNL _____ Other _____

CXR: WNL _____ Other _____

Labs: _____

Anesthesia Type: General _____ Regional _____ MAC _____ Local _____

ASA Physical Status 1 2 3 4 5 E

 Reviewing Physicians Signature Date(Day of Surgery)



Normal – (309) 807-0384

Pontiac – (815) 842-6551

Eureka – (309) 467-2371

Pre-operative History	Dr. _____
Patient: _____ Chief Complaint _____ min MAC/Gen	
Past History/Co-Morbidity: CAD PVD DM HTN	
Past Family, Social, and Family History: _____	
Allergies: NKDA Latex Iodine PCN other _____	
Current Meds/Dosage: None _____	

Physical Examination:								
Sex	Race	Age	Height	Weight	BP	Pulse	Resp	Temp
					/			
Mental Status		Alert & Oriented x 3 Appearance _____						
HEENT		PPERLA		EOMI		No Lymphadenopathy		
Abnormal:		Thyroid WNL		TM WNL		O/P WNL		No JVD
Cardiovascular:		RRR S1S2		S3		S4		
Abnormal:								
Pulmonary		Lungs CTA B/L						
Abnormal:								
GI		Normal Bowel Sounds		No Hepatosplenomegaly				
Abnormal:								
Musculoskeletal/Extremities		No Clubbing		No Cyanosis		No Edema		
Abnormal:		NML Muscle Tone		NML Strength				
Neurological		CN II-XII Intact		NML Mood				
Abnormal:								

Assessment:			
The surgery proposed for this patient is _____ Low Intermediate High Risk			
Plan Further testing for this patient IS NOT recommended. The patient may proceed directly to surgery.			
Further testing IS recommended for this patient. The following test(s) are to be obtained prior to the planned surgical procedure. _____			
MD/PA/NP Name (PRINT) _____		Date ____/____/____	
Provider Signature _____		Please Fax Back to: Dr. O'Connor – 815-844-4106	
When H & P documented prior to the day of surgery, attending physician or anesthesiologist must evaluate the patient's status on the day of surgery:			
Patient evaluated and remains suitable for the planned procedure.		Signature _____ Date ____/____/____	



DR. SCOTT O'CONNOR

Fellow, American College of Foot & Ankle Surgery
 Diplomate, American Board of Podiatric Surgeons
 Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

About Your Surgery

<p>It is very important that you read and follow these instructions. If you still have questions about your surgery, call your surgeon's office.</p> <p>Pre-surgery preparation The pre-surgery preparation process begins at your surgeon's office. If you need labs and an ECG before surgery, your surgeon will arrange for these. You will fill out the pre-surgery questionnaire at your surgeon's office. On the pre-surgery questionnaire you tell us about your health and tell us how you can be reached 1 to 2 days before your surgery for a telephone interview. During the telephone interview a pre-admission nurse will review the questionnaire with you, ask some additional questions, and tell you about anesthesia and what you should expect at the ASC. For your convenience, this is all done over the phone. <u>If you smoke: Try to stop smoking.</u> You will not be able to smoke while in the ASC. If you would like help with trying to stop smoking call your primary physician.</p>	<p>Before your surgery: <i>Make arrangements:</i> Arrange for an escort home. You are going home the same day of your surgery and you must have a reliable adult take you home. Arrange for someone to stay with you for the first 24 hours. Prepare your home for your return after surgery. Have shopping and laundry done. Prepare some meals ahead of time. Plan for car rides, as you may not be able to drive for a while. If you have small children, dependent adults or animals that you care for, arrange to have someone help you watch them during the first few days after surgery. On the business day before your surgery: The office will contact you in the afternoon typically to verify details of surgery, arrival and what to do or not to do. <i>The evening before your surgery:</i> It is very important that you are rested before your surgery, try to sleep.</p>
<p>Day of surgery: Remember, do not eat or drink anything unless you were given different instructions. <i>Medication:</i> If you have been instructed to take any medication take it with a small sip of water. Typically medications for High Blood pressure or seizures (not water pills). If you were told to bring medications to the ASC bring them with you. <i>Getting dressed:</i> Wear loose comfortable clothing Do not wear any jewelry. This includes wedding rings, earrings and any other body piercing. All jewelry must be removed prior to surgery. Do not wear nail polish, hair spray, body lotion, perfume or make up. <u>Remove toenail polish.</u> Diet instructions: Do not eat or drink after midnight unless otherwise instructed. This includes food, all liquids, hard candy, gum or mints. Some people are given instructions that allow them to drink clear liquids (water, apple or cranberry juice – NO ORANGE JUICE, black coffee or black tea –NO CREAM, CREAMER OR MILK, and carbonated beverages) up until 8 hours before their scheduled surgery. Please follow your instructions about eating and drinking. Otherwise, your surgery may be cancelled.</p>	<p>Getting ready: Do not bring valuables to the ASC. Bring your glasses and a case for storing them. You will not be able to wear contact lenses during surgery. Bring your dentures or hearing aides and cases for storing them. You may bring a book or a magazine to read before you go into surgery. Plan to arrive at the ASC at the time you were instructed to.</p> <p>After your Surgery: Immediately following your surgery, you will be taken to a Post Anesthesia Care Unit (PACU). A nurse will care for you until the effects of the anesthesia wear off. You may have an intravenous line. This is to give you fluids and medication until you are ready to take them by mouth. The recovery area is large, bright and cool. If you feel cold ask for a warm blanket. Expect to have pain after surgery. Your nurse will ask you to rate your pain on a scale of 0 – 10 (0 is no pain and 10 is the worst pain). This rating is used to give you pain medication.</p>
<p>Leaving the ASC: Your nurse will give you instructions before you go home. You may also have instructions from your surgeon. Your nurse will review the instructions with you and your escort or family member and give you a written copy. <i>For your pain:</i> You may get a prescription for pain medication from your surgeon to be filled or called in to your pharmacy of choice. Do not drive while taking prescription pain medication. Do not drink alcohol while taking prescription pain medication. <i>Getting home:</i> You must have a reliable adult escort you home. Arrange for someone to stay with you the first 24 hours after surgery. You may need help around the house or with getting your prescriptions filled. Do not drive for 24 hours after anesthesia. A nurse will call you the next day to check on you.</p>	<p>Important phone numbers: <i>For questions before your admission:</i> Bloomington-Normal Surgery Center - (309) 434-4000. St. James Hospital Surgery – (815) 842-2828. St. Joseph Hospital (not Eastland) – (309) 661-5000. Eureka Community Hospital – (309) 467-2371.</p> <p>OSF and Dr. O'Connor have professional, financial, and personal interest in the surgical centers you may be scheduled to go to. If you would like to discuss other facility options, please contact us.</p> <p><i>We hope this information has been helpful. If you have any questions or concerns, please call Dr. O'Connor's office.</i> Normal – (309) 807-0384 & Pontiac – (815) 842-6551.</p>

Surgery Day Guidelines

8 hours before surgery: STOP ALL FOOD, MILK AND MILK BASED PRODUCTS

Medications to take per normal routine: WITH A SMALL SIP OF WATER

- *Heart Medications – like Lanoxin/digoxin
- *Blood Pressure Meds but NOT water pills
- *Seizure Medications
- *Diabetics – ½ long acting insulin
 - DO NOT TAKE oral hypoglycemic pills
- *Antacids – Zantac, Pepcid

IF YOU TAKE ANY OF THE FOLLOWING MEDICATIONS –Let us Know

- *MAO Inhibitors
- *Diet Pills – Phenternamine, meridia, adipex, parnate
- *Coumadin/Blood thinner
- *St. John's Wort
- *Ginko
- *Kava Kava
- *Metabolife/lite

Anesthesia Orders

1. No Labs for healthy children & adults.
2. BMP/Chem 7 for diuretics, electrolyte imbalance replacement, digoxin, diabetics.
3. Hgb/Hct for history of anemia or blood loss.
4. EKG for antiarrhythmics, beta-blockers for HTN, history of CAD, Type I DM or Type II if >40 y/o.
5. CXR for COPD.