EYE SURGERY CENTERS OF NEW YORK

Medical Clearance for Surgery

Form 1

Surgeon's Name: _____

Patient Name: _____

Birth Date: _____

Date of Surgery: _____

Dear Doctor:

Thank you for seeing _____. The proposed _____ surgery is minimally invasive and is typically of duration of approximately a half (1/2) hour to fourty five (45) minutes depending upon the procedure. Please provide the following requirements for medical clearance.

1. History and Physical- Completed within 30 days of surgery date.
2. EKG completed within 180 days of surgery date.
3. Labs (CBC, SMA7) - Completed within 180 days of surgery date.
4. Patients who are on diuretics or anticoagulants and/or diabetes, renal, or liver disease must have the appropriate blood work. Please note that the potassium level for dialysis patient should be within the acceptable range and also the platelet level should be more than 80,000 mcL.
5. Please include the medication list as part of the medical clearance (if applicable).
6. If patient is using assistive device such as wheelchair, cane, walker, please indicate ambulatory status of patient.

Please fax the enclosed forms to:
Fromer Eye Centers
Attn: Surgical Coordinators Department
Phone: (718) 261 - 4190 Fax: (347) 523 - 4653

We are enclosing the pre-operative forms to be completed for the patient's surgery.

Thank you.

FROMER EYE CENTER USE ONLY:

- Please go to your primary care physician for your medical clearance by _____.
  Note: You must see your primary care provider two (2) weeks prior to your surgical date.
- Please bring these two (2) forms to your doctor:
  Please bring forms 1 & 2 to your doctor

3130 Grand Concourse, Suite B5; Bronx, New York 10458
Ph: (718) 502-3937 | Fx: (718) 295-4052

EYE SURGERY CENTERS OF NEW YORK

PATIENT HISTORY AND PHYSICAL

Form 2

PATIENT NAME: DATE:
OPERATION: AGE:
SURGEON: SEX:
DIAGNOSIS:
VITAL SIGNS: B/P _____ P _____ RR_____ SAT_____%

MEDICAL HISTORY:

SURGICAL HISTORY:

ALLERGIES/REACTION:

MEDICATIONS:

PHYSICAL EXAM: Does patient have a cognitive impairment? Yes No
DEMENTIA/ALZHEIMERS * If so, please attach HEALTH CARE PROXY**

IMPRESSION: ☐ MEDICALLY STABLE AND CLEARED FOR PROPOSED PROCEDURE IN AN AMBULATORY SURGERY CENTER.

RECOMMENDATIONS:

Please provide copy of:
☐ **LABS** ☐ **EKG**

_____**MD/DO/NP** _____ _____
PHYSICIAN PRINT SIGNATURE DATE

ESCNY Forms

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EYE SURGERY CENTERS OF NEW YORK

Our **entrance on 204th St** between Valentine & Grand Concourse **(basement)**

A nurse will call you the day before your procedure to establish a time. If you have any medical issues or have previously been hospitalized, in the last 30 days, please let the nurse know.

- You are to have nothing to eat or drink after midnight, the day of surgery, unless instructed by a staff nurse.
- You can take your blood pressure medication, antidepressant, antianxiety the morning of surgery with a little bit of water
- If you develop a cough, cold or fever: Call your surgeon as soon as possible prior to your surgery.
- **PLEASE DO NOT BRING CHILDREN THE DAY OF SURGERY**

You must be accompanied by an adult the day of surgery. If you do not have an escort, surgery will be canceled.

Bring the following with you the day of surgery:

- Payment for surgery center. A surgery center staff member will call you a week in advance to inform you of any copay, deductible or coinsurance.
- Photo ID and insurance card
- Eye drops or ointment
    - Please confirm your surgeon prescribed eyedrops/ointment with the staff nurse.

Payment due to Eye Surgery Centers of New York is separate from the physician fee you may have paid to the physician's office.

EYE SURGERY CENTERS OF NEW YORK

PATIENT AND INSURANCE INFORMATION

THE SURGERY CENTER REQUIRES THE FOLLOWING INFORMATION IN ORDER TO FILE YOUR INSURANCE CLAIM (S). ALL CLAIMS ARE PROCESSED ACCORDING TO THE PATIENT'S PARTICULAR PLAN. DEDUCTIBLES, CO-INSURANCE, AND NON-COVERED SERVICES MAY APPLY AND ARE THE RESPONSIBILITY OF THE PATIENT.

NAME OF SURGEON: _____

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY# _____

HOME ADDRESS _____ HOME PHONE # _____

CITY _____ STATE _____ ZIP _____

BUSINESS PHONE# _____ CELL PHONE # _____

PROCEDURE(S)	CPT		
	CPT		
	CPT		

Left ☐ Right ☐ Bilateral ☐ Authorization Required: ☐ No ☐ Yes If Yes, Authorization# _____

DIAGNOSIS(ES)	ICD-10		
	ICD-10		
	ICD-10		
	ICD-10		

PRIMARY CARE PHYSICIAN

NAME _____

PHONE# _____

FAX# _____

EMERGENCY CONTACT

NAME: _____

PHONE# _____

Relationship to patient _____

Primary Insurer _____

Policy Holders Name _____

Relation to Patient _____

Policy # _____ Group# _____

Policy Holders Date of Birth _____

PRECERT# _____ Date _____

Secondary Insurer _____

Policy Holder's Name _____

Relation to Patient _____

Policy # _____ Group# _____

Policy Holders Date of Birth _____

PRECERT# _____ Date _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE EYE SURGERY CENTERS OF NEW YORK ANY SERVICES FURNISHED ME BY THIS SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND/OR TO ANY OTHER INSURANCE CARRIER (S) ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT SIGNATURE _____ DATE/TIME _____

EYE SURGERY CENTERS OF NEW YORK

CONSENT FOR SURGERY & ANESTHESIA

_____ Date of Birth _____ is scheduled for outpatient surgery at the **Eye Surgery Centers of New York.**

Name of Operation: _____

_____

Surgeon: _____, MD and Assistant Surgeon

The advantages and disadvantages of outpatient surgery have been explained to me and I understand them. I realize that following my operation; admission to a hospital may be necessary. I agree to be admitted to St. Barnabas Hospital, 4422 Third Ave, Bronx, NY 10457 (718) 960-9000 if my doctor deems it necessary.

I consent to the disposal of any tissues that are removed surgically.

Following surgery, I will not drive myself home or use public transportation.

I realize that, following administration of medication or anesthesia, my mental alertness may be impaired for several hours. I will not make any decisions or participate in any activities that depend on full mental alertness during that time.

IF APPLICABLE, I certify that at this time, **I AM NOT PREGNANT**.

To the best of my knowledge, all the answers to the questions I have been asked are true and I have not withheld any information.

I hereby consent to the proposed operation and the administration of the necessary pre-operative, operative and post- operative medications.

_____ _____

Signature of Patient/Guardian Date/Time

_____ _____

Doctor Date/Time

_____ _____

Witness Date/Time

EYE SURGERY CENTERS OF NEW YORK

PRE-OPERATIVE HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

Have You Ever Had:

☐ Yes ☐ No Heart Issues
☐ Yes ☐ No High Blood PressurePres
☐ Yes ☐ No Asthma or Breathing Problems
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Stroke
☐ Yes ☐ No Epilepsy or Convulsions
☐ Yes ☐ No Bleeding Tendency
☐ Yes ☐ No Jaundice, Hepatitis or Liver Problems
☐ Yes ☐ No Chronic Back Problems
☐ Yes ☐ No Anxiety Problems
☐ Yes ☐ No Kidney Disease or Urinary Tract Infection
☐ Yes ☐ No A Bad Reaction to Local or General Anesthesia. If Yes, indicate type of Anesthesia & Reaction:_____
☐ Yes ☐ No Abnormal Chest X-ray
☐ Yes ☐ No Abnormal EKG
☐ Yes ☐ No Allergic to Latex
☐ Yes ☐ No Allergic to Betadine
☐ Yes ☐ No Allergic to Seafood
☐ Yes ☐ No Allergies or Reactions to Drugs. If Yes, Please List:_____

Do You:

☐ Yes ☐ No Wear Contact Lenses
☐ Yes ☐ No Wear a Hearing Aid
☐ Yes ☐ No Have Dentures, Caps or Bridges?
☐ Yes ☐ No Use assistive device such as cane, walker, crutches, wheelchair?
☐ Yes ☐ No Smoke? If so, How Much? _____
☐ Yes ☐ No Drink Alcohol? Is so, How Much Per Day? _____
☐ Yes ☐ No Have an automatic internal defibrillator and/or Pacemaker?
☐ Yes ☐ No Have you currently or in the past taken Flomax or Tamsulosin?
☐ Yes ☐ No Take any prescription medications? If yes, please bring a list on the day of surgery.
☐ Yes ☐ No Have Alzheimer's, Dementia or Memory problem or do you take any medication for memory such as Aricept, Donepezil, Exelon, Razadyne, Namenda, Memantine? If so, will require HealthCare Proxy.
☐ Yes ☐ No Currently admitted in the Nursing Home Facility or Rehab center. If yes, indicate the ambulatory status and **ALERT** the ESCNY.
Ambulatory Status: _____

_____ _____
Signature of Patient/Guardian Date/Time

_____ _____
Witness Date/Time

EYE SURGERY CENTERS OF NEW YORK
ACKNOWLEGMENT FORM

I, _____, acting as a (circle appropriate designation) patient, patient's representative, relative, do hereby acknowledge receipt, review, and the opportunity to ask any questions about the following.

- The description of law prepared by the Department of Health entitled, "Planning in Advance for Your Medical Treatment".
- The pamphlet prepared by the Department of Health entitled "Appointing Your Health Care Agent- New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding about CPR: Do Not Resuscitate orders (DNR)".
- A handout entitled, "Ten Basic Questions and Answers for Consumers on the Patient Self- Determination Act".

I further do hereby acknowledge that, prior to the day of the surgical procedure, I received and reviewed the following documents:

- Patients' Rights and Responsibilities
- Informational Document on Advance Directives
- A disclosure of financial interest in this facility from my physician (if applicable)

I further do hereby acknowledge that Patients Rights and Responsibilities and this facilities policies regarding Advance Directives were verbally explained to me by a representative of this facility, prior to the date of surgery, to my satisfaction.

I further attest that I have informed EYE SURGERY CENTERS OF NEW YORK of the existence, if any, of instructions pertaining to Advanced Directives, Living Wills, DNR Orders, Health Care Proxy, or other form of an expression of patient self-determination. I have/will provide a copy of the duly executed instrument and acknowledge that said copy will become a part of the patient medical record.

I have an Advanced Directive { } No { } Yes Type: _____

I understand and acknowledge that it is the responsibility of the patient, or his/her representative, to inform EYE SURGERY CENTERS OF NEW YORK immediately of any change in the conditions of the above mentioned expression of patient self-determination.

_____ _____

Print patient's name

Patient, representative, relative
Signature (Circle appropriate one)

_____ _____

Witness Signature

Date