Surgical Information - Patient Responsibility

Please review the following information carefully. All steps must be completed before your surgery.

Contact our office if you have any questions (301) 530-6699

Patient name: __________________________
Surgery Date: __________________________
Facility: _______________________________

Patient Pre-Operative Instructions –

1. It is your responsibility to schedule an appointment to have your pre-operative evaluation with your primary care physician. Please bring the required History and Physical form to your appointment. This form can be found at www.docplot.com/download.htm. Scroll down the page and locate name of the hospital where your procedure is scheduled, then click the History & Physical link. Please have the results faxed to (301) 581-0969 at least 4 days prior to surgery. Failure to complete this form may result in cancellation of surgery.

   ____ History and Physical
   ____ EKG (required for men over 40 and women over 50)
   ____ LABS – only if PCP requires for surgical clearance

   If taking daily medication, check with your prescribing doctor concerning their use on day of surgery and notify Dr. Plotsky.

2. Arrange for a ride home: You will not be released without an adult to accompany you

3. On the evening before surgery you may not eat or drink anything after midnight unless instructed by the facility to do otherwise

*Our office will obtain all precertifications and referrals for your surgery
Patient Check-In Instructions

Check-in time: ________________
Place: ________________________

The surgery center - not our office - will confirm check in time at the facility.

You will be notified of your check-in time by the nurse at the hospital a few days prior to your surgical date. All surgery times are approximate.

Suburban Outpatient Surgery Center ………….. 301-896-6700
Children’s Ambulatory Surgery Center …………. 301-424-1755
Washington Hospital Center ………………… 202-877-7000
Georgetown University Hospital ……………….. 202-444-2000

You may anticipate staying at the surgery center about 2 hours after the surgery begins.

Patient Post-Operative Instructions

Eye Muscle Surgery: Use antibiotic ointment twice a day in operated eye. Use cool compresses for 48 hours. Make an appointment to see Dr. Plotsky within 1 week.

Tearduct Surgery: Use eyedrops twice a day for 5 days. Make post-op appointment 2-3 weeks following surgery.

Chalazion Excision: Use Tobradex ointment twice a day for 1 week. Use warm compresses twice a day. Make post-op appointment 3 weeks following surgery.

OTHER:
ATTENTION!!!

You must take this form with you to your pre-operative physical.

It is your responsibility to take this form with you to your appointment. Failure to take this form to your appointment may result in a rescheduling of your appointment and/or surgery.

Your doctor’s office should fax the completed form to:
301-581-0969

In addition, please obtain a copy of the completed form and take it with you to your surgery. This will ensure that you are cleared for your operation.

Check with your insurance company for participating clinics.

Diagnosis code: ________________________

Procedure code: _______________________
Chief Complaint:  

History of Present Illness/Injury:  

Pain Assessment: Pain:  □ No  □ Yes  

WONG-BAKER FACES PAIN RATING SCALE  
(Recommended for children 3 years/or >)  

0 1 2 3 4 5  

Location:  

Character:  Dull  □  Sharp  □  Throbbing  □  

Frequency:  

Duration:  

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. 

Face 0 is very happy because he doesn't hurt at all. 

Face 1 hurts just a little bit. 

Face 2 hurts a little more. 

Face 3 hurts even more. 

Face 4 hurts a whole lot. 

Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. 

Ask the person to choose the face that best describes how he is feeling.  

Review of Systems:  

Past Medical/Surgical History:  

Bleeding Tendencies:  

Family History/Psychosocial Assessment:  

Immunizations up to date?  □ Yes  □ No  

Allergies:  

Present Medications:  

*PHYS H+P*
Physical Exam:

Legend: Place an “X” if abnormal, “✓” if normal, and leave blank if not examined.

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- General Appearance (State)
- Head
- Fontanel
- Ears
- Nose
- Mouth/Teeth
- Pharynx
- Lymph Nodes
- Cardiovascular
- Lungs
- Abdomen
- Genitals
- Anus / Rectum
- Skin / Scalp
- Neurological
- Skeletal (Back, Hips, Extremities)
- Development
- Growth

Describe all abnormalities:

Labs/Radiology:

Assessment (Medical or Surgical Indications for Admission):

PLANS:

EDUCATION: Diagnosis, Treatment Plan and Medications discussed and reviewed with patient/family.

I certify that this admission is medically necessary.

Fellow/Resident/Practitioner: Signature: __________________________ Date: ____________

Print Name: __________________________ Date: ____________

Attending:

Patient examined, no pertinent changes from above: ☐

Signature: __________________________ Date: ____________

Print Name: __________________________ Date: ____________