



David F Plotsky, MD, PC  
Pediatric Ophthalmology & Adult Strabismus  
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## 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](http://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



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### **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:**



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# 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: \_\_\_\_\_



**Children's**  
National Medical Center  
111 Michigan Avenue, NW  
Washington, DC 20010

**SURGICAL H & P**

**PART B - Interdisciplinary Patient Assessment**

PATIENT I.D. \_\_\_\_\_

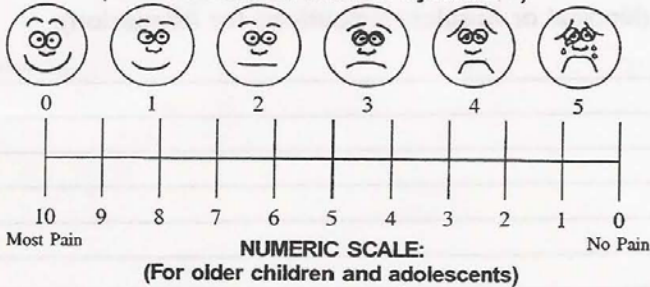
**Chief Complaint:** \_\_\_\_\_

**History of Present Illness/Injury:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pain Assessment: Pain:**  No  Yes

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



**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.

T: P: R: B/P: Ht. Wt. HC:

- 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:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attending:**

Patient examined, no pertinent changes from above:

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_