Northwell Health | Syosset SurgiCenter

240 Jericho Tpke.
Syosset, NY 11791

T: 516 517-5300 F: (516) 730-2305

To all our patients:

Thank you for choosing the Syosset SurgiCenter for your medical care. We look forward to meeting you on the day of your procedure as well as providing you with a unique, comfortable health care experience

In order to ensure that your time at the Syosset SurgiCenter is as stress free and as pleasant as possible, please complete the attached documents **before** arriving at the Syosset SurgiCenter. It is required by New York State and Federal regulations that these forms be completed.

Directions for completing documents:

I. History & Physical Form: *OPHTHALMOLOGY PATIENTS ONLY*: Please call your medical doctor to schedule an appointment for your medical clearance. Your medical clearance must be **no more than 30 days** before your scheduled surgery date. Your medical doctor must complete this form and fax it to the Syosset SurgiCenter at least 5 days before your date of surgery.
ALL OTHER PATIENTS: please check with your surgeon.

II. Pre-anesthesia Survey Form: Please complete **both** pages of this form. You must bring the **completed** form with you on the day of your surgery.

III. Medication Reconciliation Form: (as the patient, you should complete this form, but you may ask your medical doctor for assistance if you are unsure of any medication or allergy). **You will only complete the top 2 sections of this form in white, the gray areas are for doctor's use only.**
   a. Complete "List All Allergies". List allergy and please note reaction.
   b. Complete: Medication Name, Dose, Frequency and Indication ONLY.
   c. **DO NOT complete anything else on this form.**
   d. You must bring the **completed** form (only complete the sections noted above) with you on the day of your surgery.

PLEASE NOTE: Payment is expected at the time of check-in. Any and all copayments, deductibles and/or coinsurances you are assessed are expected to be paid in full at the time of check in. A representative from our Insurance Department will be contacting you prior to your surgery date.

If you have any questions regarding the attached forms, contact the Syosset SurgiCenter immediately at 516-517-5300.

The Staff of the Syosset SurgiCenter

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History & Physical

Patient's Name: _____ **Date of Surgery:** _____

Name of Surgeon: _____ **Pre-op Diagnosis:** _____

Procedure: _____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Allergy/Sensitivity Section ONLY	No	Yes	If yes to allergies or sensitivities, please specify:
Allergy and/or Sensitivity **to Medications**			
Allergy and/or Sensitivity **to Iodine or Shellfish**			
Allergy and/or Sensitivity **to Latex**			
Allergy and/or Sensitivity **to Other**			

History	No	Yes	If yes, please specify:
Sleep Apnea			
Cardiac: MI, Angina, CHF, Arrhythmia, HTN			
Vascular: Aneurysm, PVD			
Pulmonary: COPD, Asthma			
Neuromuscular: Myasthenia, MS, Seizures			
Genito-Urinary: Failure, Calculi			
Endocrine: Diabetes, Thyroid, Adrenal			
Hepato: Jaundice, Hepatitis			
Musculoskeletal: Arthritis, Osteoporosis			
Coagulopathy			
Gastrointestinal: Ulcer, Colitis			
EENT: Glaucoma, Deafness			
Previous Surgery: Date and Type			
Immunizations Current			
Psychological or Social Problems			**Please List Current Medications/Dose/Frequency**
Smoke			
Drink Alcohol			
Use Recreational Drugs			
Females Only			
Possible pregnancy now			
Last Menstrual Period (Date)			

Physical Examination							
Head		Lymph Nodes		Back		**Vital Signs**	
Skin		Breasts		Genitalia		BP	
Eyes		Lungs		Rectal		Pulse	
Ears, Nose, Throat		Heart		Extremities		Respirations	
Mouth, Teeth		Abdomen		Neurological		Height	
Neck, Thyroid						Weight	

Please attach copies of all Laboratory Reports & EKG

Comments and/or impression:

☐ **Patient Medically Cleared for Surgery in an Ambulatory Surgery Center**

☐ **Patient NOT Medically Cleared for Surgery**

_____

_____

_____ _____ _____

Physician's Signature Physician's Name (print) **Date**

Please fax this form to Syosset SurgiCenter **(516) 730-2305 AT LEAST 5 days prior to surgery.**

Medical clearance MUST be within 30 days of the date of the scheduled procedure.

Northwell Health® | Syosset SurgiCenter

All Patients:

Please Bring the Following forms Completed to the Syosset Surgicenter on the Day of your surgery:

- Pre-anesthesia Survey
- Medication Reconciliation form (you must list all the medications you are taking on this form-no attachments will be accepted)

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Pre-anesthesia Survey **Name:** _____

Patient Questionnaire – Please complete and bring this form with you on the day of surgery.

Please list all of your **allergies** (medicines, tape, etc.) _____

Medical History: (If the answer to any of the following is Yes, please explain)

___ No ___ Yes Do you have Sleep Apnea? _____
___ No ___ Yes Anemia / bleeding disorder / sickle cell disease _____
___ No ___ Yes Congestive heart failure / asthma / emphysema / breathing problems _____
_____
___ No ___ Yes Cancer _____
___ No ___ Yes Diabetes _____
___ No ___ Yes Hypertension _____
___ No ___ Yes Heart disease / chest pain / angina / heart "attack" _____
___ No ___ Yes Stroke / paralysis _____
___ No ___ Yes GI (stomach) disorders / hiatal hernia _____
___ No ___ Yes Liver disease / hepatitis _____
___ No ___ Yes Seizure disorder / epilepsy _____
___ No ___ Yes Psychological disorder /anxiety / depression / claustrophobia _____
___ No ___ Yes Ever had a blood transfusion? _____
___ No ___ Yes Do you smoke? _____
___ No ___ Yes Do you drink alcohol? _____
___ No ___ Yes Do you take any recreational drugs? _____
___ No ___ Yes Have you or any of your relatives had a problem with an anesthetic? _____
_____
___ No ___ Yes Chronic pain _____
___ No ___ Yes Do you have a physical impairment which limits the motion of joints, (arms, neck, back, legs)? _____
___ No ___ Yes Do you have difficulty opening your mouth or moving your head or neck? _____
_____
___ No ___ Yes Do you have loose teeth, caps or dentures? _____
___ No ___ Yes Do you have any implantable devices e.g. pacemaker, defibrillator? _____
_____
___ No ___ Yes Do you have a cold or other acute illness? _____
___ No ___ Yes Females Only – Could you be pregnant? Last menstrual period _____

PLEASE COMPLETE 2nd PAGE

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Pre-anesthesia Survey – PAGE 2 **Name:** _____

Please list all previous surgeries you have had (type of surgery and when).

_____

_____

_____

_____

_____

Have you had anesthesia before? ___ No ___ Yes. If yes, did you have any adverse reactions to anesthesia? _____

*** **Please complete the "Medication Reconciliation" form. List all medications** you have taken in the **past 6 months** including prescriptions drugs, over-the-counter medicines (e.g. aspirin), inhalers and herbal or dietary supplements.

Please list any additional information you feel would assist us in providing the best and safest possible care for you.

_____

_____

Please sign below that you have completed this form to the best of your knowledge and are satisfied that you understand the questions.

Patient Signature _____ **Date** _____

Anesthesiologist Signature _____ **Date** _____

Anesthesiologist Name (print) _____

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Form #3

Patient's Name: _____

Medication Reconciliation Form

(LIST ALL ALLERGIES)

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:

List ALL medications, vitamins, herbal, over the counter, pumps, patches, inhalers, sprays, ointments.
GRAY AREAS FOR SURGICENTER USE ONLY:

Medication Name	Dose	Frequency (How Often)	Indication (Reason)	Medication Taken Today YES	Medication Taken Today NO	Resume Medications After Discharge YES	Resume Medications After Discharge NO
				☐	☐	☐	☐
				☐	☐	☐	☐
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BELOW THIS LINE CENTER USE ONLY

Source: ☐ Patient ☐ Family ☐ Provided List ☐ History & Physical (PCP) ☐ Other _____
Admitting Nurse: _____

You may resume all medications marked "YES" in table above (last column labeled: "Resume Medications After Discharge". If you have any questions, please contact your primary care physician.
**** Your surgeon is resuming the start of your medication based on the information provided by you, including the name of the medications, dosages and frequency.**

New Medication Prescribed Following Your Surgery		
Medication	Dose / Route / Frequency	Next Dose

_____
Physician's Signature

Please bring this medication record with you to your primary care physician's office.

_____ _____
Nurse's Signature **Date**