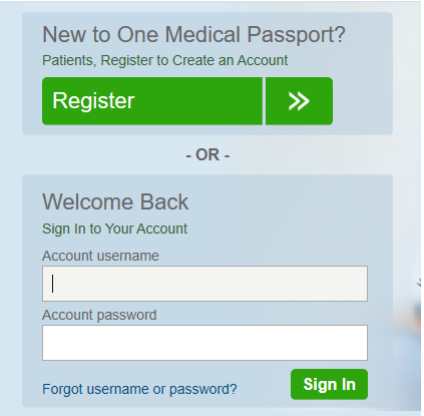
SURGERY CENTER OF FAIRBANKS

PATIENT REGISTRATION & SURGERY INFORMATION



Name: _____

Date of Surgery: _____

Surgery Time: Surgery times are finalized the day before the surgery and we will call you after 3:00 p.m. with your time. Call us at (907) 458-7263 if you have questions.

PRIOR TO SURGERY

All patients pre-register online

- Go to SCFAIRBANKS.COM and select REGISTER at least 1 day before your surgery. A preoperative nurse will call you the day before to go over your submitted health history.

Patients scheduled for a total joint replacement or spine surgery

- Schedule an appointment with a preoperative nurse at (907) 458-7263

Children under the age of four

- Schedule an appointment with a preoperative nurse at (907) 458-7263

THE DAY BEFORE SURGERY

1. Stay well hydrated by drinking plenty of water.
2. DO NOT EAT OR DRINK AFTER MIDNIGHT includes coffee, tea, water, gum, and mints. Your surgery will be canceled if you eat or drink.
3. MEDICATION instructions will be done when we notify you about your surgery time.

ON THE DAY OF SURGERY

1. Please bring your ID and insurance card.
2. DO NOT smoke the day of surgery, including Marijuana and/or chewing tobacco
3. DO NOT TAKE anti-inflammatories, vitamins or herbal medications including aspirin, Ibuprofen, Motrin, Advil, Aleve, Nuprin, etc. 7 days before surgery (Tylenol is okay).
4. If a special prep or medication has been prescribed by your physician for use before your surgery, please follow the instructions closely.
5. You may brush your teeth, bathe and shower before coming to the surgery,
6. Do not wear ANY make-up, lotion, creams, deodorant, or remove fingernail polish.
7. Bring you contact lens case so they can be removed prior to surgery or glasses case.
8. CHILDREN:
    a. Have breast milk 4 hours before surgery.
    b. Finish 8 ounces of clear liquids* 2 hours before surgery
    c. May bring a special item for comfort.
    d. Children cannot be left unattended in the waiting room.
    e. Parents remain in the building the entire time.

*Clear liquids includes ONLY water, plain jello, a popsicle, clear apple juice, coffee or tea (NO milk)

AFTER SURGERY

1. Your doctor will give you discharge instructions specific to your surgery. Please call the doctor's office if you have any concerns.

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IMPORTANT INFORMATION ABOUT MEDICATIONS

Aspirin, NSAIDS and Blood Thinners:
These medications can cause an increase in bleeding and their continued use could make it necessary to reschedule or cancel the procedure. It is important to **discontinue their use for at least seven (7) days prior to your procedure, *unless* your provider has instructed you otherwise.** They may be resumed two (2) days after the procedure unless your provider states otherwise. Please follow your provider's order and recommendations.

The following is a list of the commonly used NSAIDs (non-steroidal anti-inflammatory drugs). New medicines are released frequently. If you take any medicines you feel may be similar, *please seek the advice of your provider* at least seven (7) days before your scheduled procedure.

Advil	Feldene	Nabumetone
Aleve	Fenoprofen	Naprosyn
Anacin	Flubiprofen	Naproxen
Anaprox	Ibuprofen	Orudis
Ansaid	Indocin	Oxaprozin
Aspirin	Indomethacin	Piroxicam
Choline & Magensium	Ketoorofen	Relafen
Davoro	Ketorolac	Salicylate (all meds with salicvlate)
Diclofenac	Lodine	Sulindac
Disalcid	Meclofenamate	Suprofen
Ecotrin	Mobic	Tolmectin
Etodolac	Motrin	Toradol
Excedrin	. .	Volatren

....***Cold and sinus medicines with aspirin or Ibuprofen***
There is no need to discontinue Tylenol (acetaminophen) or COX-2 inhibitors (Celebrex, Bextra) .

Blood Thinners:
If you take Coumadin (Warfarin) or other blood thinners such as Plavix (Clopidogrel), Pletal (Cilostazol), Ticlid (Ticlopidine), Trental (Pentoxifylline), Lovenox (Enoxaparin), Aspirin, etc., *notify your provider.* The medication may need to be discontinued and additional blood tests performed prior to your procedure.
Diabetic medications: Do not take Insulin or Diabetic medications the day of your procedure unless your provider has instructed you otherwise. Bring the medications with you to take afterward as needed.
Other: Also inform your provider if you are taking Antibiotics or large Doses of vitamins as these may interfere with the procedure.

Other routine medications not listed above may be taken with a sip of water up until 2 hours prior to procedure. Nothing else by mouth *including gum or mints* 6 hours prior to procedure.

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SCHEDULING FORM

[ ] 23 Hour Stay

Date of Surgery:	Surgeon:
Parents/Guardian Name:	
Patient Name (Last, First):	
Phone: [ ] Cell [ ] Home	E-mail:
DOB:	
Sex: ○Male ○Female	Height:____ft.___in. Weight: ____lbs. BMI:_____
Allergies:	
Surgical Procedure: Surgery Length:	
Diagnosis:	
CPT:	
Anesthesia Type:	☐General ☐Local/Sedation ☐Regional
	☐Spinal ☐MAC ☐Other
Insurance:	
Pre-cert:	
Special Equipment & Requests:	
Implants:	
Allograft:	Size:
C-Arm:	Position: ☐Supine ☐Beach ☐Prone ☐Lateral Recumbent
Crutches:	Other:

Please attach demographics (insurance & address) and fax to: (907) 458-7264

Questions or issues please call Keli Hite McGee, Administrator, 458-7263

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CONSENT FORM

1. I hereby authorize **Dr**_____to perform the following operation on the patient named below, the procedure to be performed is

_____

_____

_____

_____

2. The nature of the operation or procedure has been explained to me. I have been informed of the usual risks and benefits, as well as of alternative treatments. I acknowledge that no guarantee or assurance has been made as to the results or cure that may be obtained from this procedure. I understand and accept the possibility of risks and complications.
3. I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those set forth in Paragraph 1. I therefore further authorize and request that the above-named physician perform such procedures as are in his/her professional judgment, necessary and desirable. The authority granted under this Paragraph shall extend to remedying conditions that are not known at the time of the procedure.
4. I hereby authorize the physician to use his/her discretion in the disposal of any severed tissue or member.

I hereby authorize and direct the physician named above to provide such additional services for me as he or she may deem necessary and reasonable. This includes but is not limited to the administration and maintenance of anesthesia or moderate sedation and the performance of services involving pathology and radiology. Although rare, several complications with anesthesia can occur and include the possibility of infection, bleeding, drug reactions, blood clots, permanent loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

For patients electing to receive moderate sedation:

I acknowledge that the options and risks associated with sedation have been explained to me by my provider. The expected result for moderate sedation is: a depressed level of consciousness while retaining the ability to independently and continuously maintain a patent airway and respond appropriately to physical stimulation and/or verbal commands. Moderate sedation is achieved through the following method: medications intravenously injected into the bloodstream. Risks include but are not limited to: an unconscious state, depressed breathing, injury to blood vessels and/or allergic reaction.

I HAVE READ AND UNDERSTAND THE ABOVE. ALL THE BLANKS ARE FILLED IN. I DO NOT REQUIRE ANY FURTHER EXPLANATION OF THE RISKS OR POTENTIAL COMPLICATIONS OF THIS OPERATION OR OTHER INVASIVE PROCEDURE.

_____ _____ _____

Print Patient Name **Patient or Legal Guardian Signature** **Date & Time**

Relationship to Patient (if not self) _____

_____ _____

Witness Signature **Physician Signature**

2310 Peger Road, Fairbanks AK 99709 *(907) 458-7263 PH* *(907) 458-7264 FAX*

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PREOPERATIVE ORDERS

Drug Sensitivity	1. NONE ( )	
Patient Full Name:		Date of Birth:
Surgery Date:	Time of Surgery:	Duration:

☐ Day Surgery

Diagnosis:

Procedure:

Types of Anesthesia:

☐ General ☐ Local Standby ☐ Local ☐ Regional Block ☐ Conscious Sedation

Anesthesiology consult call to consult: (907) 458-7263

Anesthesia Standing Orders:

CBC	(>60 years old within days)
EKG	(>60 years old within 1 year)
Lytes	(if on Digoxin, diuretics or pt >60 years old within 30 days; if abnormal repeat)
BUN CREAT. Glucose	(> 60 years old within days)
Qualitative BHCG	For all menstruating females within 24 hours. **Exception:** Tubal ligation, hysterectomy, or menopausal for 2 or more years.
BMI	≥ 34 (if above please contact anesthesia)

Physician lab orders:

☐ CBC ☐ Beta HCG ☐ Hep screen

☐ Lytes ☐ PT/PTT ☐ HIV

☐ U/A ☐ Chem 8 ☐ VDRL

☐ FBS ☐ CMP

☐ Other: _____

☐ Chest xray ☐ EKG

☐ Other: _____

☐ Antibiotic: _____

☐ NPO after: _____

☐ Prep: _____

Should patient take chronic meds prior to surgery: ☐ YES ☐ NO

☐ SCDs ☐ TEDS ☐ OTHER:_____

☐ ALL Outside Faxes to be delivered to Admitting and faxed to 907-458-7264 prior to scheduled procedure.

☐ H&P faxed ☐ Dictated

Additional Comments: _____

Physician's Signature: _____ Date: _____