

VISION ONE LASER AND SURGERY CENTER
PHYSICIAN PREOPERATIVE HISTORY & PHYSICAL/CLEARANCE

Dear Provider:

A pre-operative evaluation & clearance is required for this patient who is scheduled for elective outpatient surgery.

An EKG is not required for cataract patients but is required for oculoplastic and retinal surgery patients to include interpretation and tracing. All CKD3 & CKD4 patients require a metabolic panel & potential clearance from Nephrologist. All patients with extensive Cardiac hx i.e. stenosis require a recent ECHO with EF% along with most recent Cardiology office visit note. If you feel additional testing is necessary, please indicate below. Please complete this form and then **FAX TO: 484-203-3019 as soon as possible**. Thank you.

Surgeon, Vision One Laser and Surgery Center

Patient's Name _____ Surgery Date _____

DOB: _____ Diagnosis _____

Proposed Surgery _____ Proposed Anesthesia ☐ Local
☐ MAC
☐ General Anesthesia

Significant Past Medical History:

Current Medications ***Please note: all GLP-1 & SGLT2 medications need to be held prior to surgery – time frame is dependent on specific medication.****

Allergies:

B/P _____ / _____ Pulse _____ Resp _____ Weight _____ Height _____ BMI _____

Heent _____

Lungs _____

Cardio-Vascular _____

Abdomen _____

Extremities _____

Neuro/Psych _____

Remarks _____

Medical Condition Acceptable for Proposed Procedure ☐ Yes

Physician Name and Address (Print or Use Stamp)

AFFIX PATIENT LABEL HERE

Physician's Signature

Date

EYE SURGERY CENTER OF CHESTER COUNTY, LLC
 140 JOHN ROBERT THOMAS DRIVE, EXTON, PA 19341
 PHONE #: 610-280-9144 FAX #: 610-280-0797

PRE-ANESTHESIA HEALTH SURVEY QUESTIONNAIRE

NAME: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

PROCEDURE DATE: _____ PROCEDURE: Cataract Surgery

SURGEON: _____

1. Please complete this form and have it available for your surgery day.
2. If you should have any questions or do not understand some of the items, we will clarify them at the time of your interview.
3. Please use the comment space to explain any "yes" answers and please provide dates if possible.

Any Latex allergies: N Y _____ Have you ever had a problem with anesthesia or
 Do you smoke: N Y _____ /Packs/Day _____ with Malignant Hyperthermia? N Y _____
 Do you drink alcohol? N Y _____ How much? _____
 Do you do recreational drugs? N _____ Y _____ Has anyone in your family had a problem with
 Could you be pregnant? N _____ Y _____ anesthesia or Malignant Hyperthermia? N Y _____
 LMP _____

Do you have any of the following:		Do you have a history of:	
Asthma or Bronchitis	N Y	Irregular heartbeat or arrhythmia	N Y
Emphysema	N Y	Heart murmur/Chest pain	N Y
Difficulty breathing	N Y	Mitral valve prolapse	N Y
Sleep apnea	N Y	High blood pressure	N Y
Diabetes	N Y	Heart attack/angina	N Y
Kidney problems	N Y	Peptic ulcer disease	N Y
Bladder problems	N Y	Hiatal hernia	N Y
Thyroid disease	N Y	Gastric ulcer/acid reflux	N Y
Sickle cell disease	N Y	Hepatitis/liver disease	N Y
Bleeding problems	N Y	Stroke	N Y
Anemia/blood transfusion	N Y	Epilepsy/seizure	N Y
Neck/back pain	N Y	Resistant infection isolation	N Y
Arthritis	N Y	Migraines or headaches	N Y
Muscle weakness	N Y	Do you wear contacts or glasses	N Y
Any additional comments or concerns not mentioned above?		Do you have hearing aids	N Y
		Do you have any loose/chipped teeth	N Y
		Do you have dentures, caps, bridgework or braces	N Y

Signature: _____

Date/Time: _____

**VISION ONE LASER AND SURGERY CENTER
PATIENT MEDICATION RECONCILIATION LIST**

To insure Quality of Care for our patients, the doctors of Vision One and our department of Anesthesia request that all patients please fill out a current medication list with dosage and how many times a day you are required to take this medication.

Patient Name: _____ **Date of Birth** _____

Vitamins & Supplements Strength/Dose

<u>Medication & Dosage</u>	<u>times/day</u>	<u>Last Taken</u>	<u>Medication & Dosage</u>	<u>times/day</u>	<u>Last Taken</u>
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INHALERS _____

BLOOD THINNERS ON HOLD ☐ **YES** date since _____ date restart _____ ☐ **NO**

OXYGEN As needed _____ at night _____ Daily Liters/minute _____

Patient Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____

Reviewed by: _____ **Date:** _____

**** PLEASE BRING COMPLETED LIST WITH YOU ON YOUR PROCEDURE DAY ****

VISION ONE LASER AND SURGERY CENTER

PATIENT ALLERGY HISTORY

PATIENT NAME: _____

SEVERITY: Please list your allergies according to the listed categories and rate your reaction according to the following scale:

M- MILD Rash, itching, hives, nasal congestion, nausea, diarrhea, dizziness, headache

S-SEVERE Swelling, fever, palpitations (fluttery heartbeat)

L-LIFE THREATENING Difficulty breathing, swelling of lips or tongue, difficulty swallowing, heart racing too fast to count

Drug, e.g. penicillin, sulfa, Percocet, darvocet, codeine, anesthesia	Reaction	Severity	Date First Occurred	Last Exposure
<i><u>For None Check Here</u></i>				
SUBSTANCE, e.g. latex, tape, IV dye	Reaction	Severity	Date First Occurred	Last Exposure
<i><u>For None Check Here</u></i>				

FOOD, e.g. eggs, shellfish, bananas	Reaction	Severity	Date First Occurred	Last Exposure
<i><u>For None Check Here</u></i>				
ENVIRONMENTAL, e.g. dust, mold	Reaction	Severity	Date First Occurred	Last Exposure
<i><u>For None Check Here</u></i>				
ANIMAL, e.g. cat, rabbit	Reaction	Severity	Date First Occurred	Last Exposure
<i><u>For None Check Here</u></i>				

PATIENT SIGNATURE: _____

DATE: _____

PRE-OP INSTRUCTION SHEET

Patient Name: _____ DOB: _____

1. Surgery Date: _____

2. The History & Physical (H&P) form, labs and EKG (if required) must be received at Vision One by _____
or your surgery may have to be cancelled/postponed.

3. a) Arrive at the Center by: **Vision One will call day before with time**

b) Anticipated discharge time from the Center: **2-3 hours**

4. **ABSOLUTELY NO FOOD AFTER MIDNIGHT THE NIGHT BEFORE SURGERY.**

NOTHING to drink after midnight the night before surgery. INCLUDING WATER, gum, hard candy or cough drops.

5. You may brush your teeth—but do not swallow any liquid.

6. a) If so instructed by the surgeon or anesthesiologist, bring all current medications with you on the day of surgery.

b) On the morning of your surgery, take the following medications with a sip of water:

c) If you are a diabetic, please check your blood sugar the morning of surgery. Do NOT take your insulin or diabetes medications unless specifically directed to do so by a physician. Please bring your insulin with you.

d) Use and bring inhaler(s)

e) _____

7. YOU MUST HAVE AN ESCORT AVAILABLE AT THE TIME OF DISCHARGE AND HAVE A RESPONSIBLE ADULT AT HOME WITH YOU FOR 24 HOURS AFTER YOUR PROCEDURE. PARENTS/GUARDIANS MUST NOT LEAVE THE CENTER WHEN THEIR CHILD IS IN SURGERY. IF YOU ARE PLANNING TO TAKE A BUS, CAB, OR PARATRANSIT AS YOUR MEANS OF TRANSPORTATION, THE DRIVER CANNOT BE CONSIDERED YOUR ESCORT. FAILURE TO HAVE A RESPONSIBLE ADULT TO ACCOMPANY YOU HOME CAN RESULT IN THE CANCELLATION OF YOUR PROCEDURE.

8. Wear loose, comfortable clothing since you will be changing into a hospital gown.

9. DO NOT wear contact lenses; DO NOT wear eye or face makeup.

10. Leave jewelry and valuables at home: The Center is unable to store them.

THE SURGICAL CENTER WILL NOT BE RESPONSIBLE FOR LOST OR STOLEN ITEMS.

11. **If you fail to follow these instructions, this may constitute a potentially dangerous risk and may lead to the cancellation of your surgery.**

12. If you have any questions call the Center at 610-280-9144 between 8a.m. and 3 p.m. the day before surgery.

13. To insure patient safety and confidentiality, we do not routinely allow family members in our recovery room.

14. Should your condition require additional care, arrangements will be made to refer you to a local hospital.

☐ I have received and understand the above instructions.

☐ Verbalized understanding of Pre-op instructions via phone.

☐ Left message.

Signature of Patient/Parent or Guardian

Date

Nurse's Signature

Date

**AFFIX PATIENT
LABEL HERE**

Eye Surgery Center of Chester County, LLC also
known as: Vision One Laser and Surgery Center
140 John Robert Thomas Dr.
Exton, PA 19341
.610-280-9144

Cataract Surgery Information

If covered by your health care insurance (Medicare, IBC, United, etc.)

- At least three separate Claims will be filed:
 - One by the surgery center for use of the facilities
 - One by your surgeon
 - One by the professional anesthesia group (does not apply to individuals covered by-an Aetna HMO plan).
- You will be responsible for any co-payments and/or deductible amounts — check with your insurance carrier if you have questions about these amounts.
- You are responsible for any amounts charged by your surgeon for use of the femto laser and/or for non-standard intraocular lenses.

If you are paying out-of-pocket for your cataract surgery:

- Fee for one eye: \$1,200.00
 - Does **NOT** include surgeon's fee
 - Does include surgery center fee
 - Does include anesthesia fee
 - Does include fee for a standard lens
 - **Must be paid in full**
 - On or before the day of surgery if paying by cash
 - On or before the day of surgery if paying by credit card
 - If paying by check, check must be received by the Center at least 3 business days prior to the date of surgery and should be made payable to; Eye Surgery Center of Chester County, LLC
- **Potential additional fees:**
 - Bilateral (both eyes) surgery on the same date of surgery; fee total = \$1,910.00, same parameters as listed above. This fee must be paid to the surgery center in accord with the cash/credit card/check parameters listed above. The surgery center does NOT accept Care Credit.
 - You are responsible for any amounts charged by your surgeon for use of the femto laser and/or for non-standard intraocular lenses.

Thank you.