Eye Surgery Center Of Chester County, LLC
DBA: Vision One Laser And Surgery Center
140 John Robert Thomas Drive • Exton, PA 19341
Phone: 610-280-9144 • Fax: 610-280-0797

PHYSICIAN PRE-OP EVALUATION

Dear Doctor:

A pre-operative evaluation is required for this patient who is scheduled for elective outpatient surgery for the following condition(s):

- ❑ Blood Pressure Disorder
- ❑ Chronic Lung Disease
- ❑ Diabetes
- ❑ Immune Disorder
- ❑ Heart Disease
- ❑ Neuromuscular Disease
- ❑ Seizure Disorder
- ❑ Dementia/Psychiatric Disorder
- ❑ CVA/Stroke/TIA
- ❑ Kidney Disease
- ❑ Anemia/Cancer/Chemo

An EKG is not required for cataract patients but is required for oculoplastic and retinal surgery patients. If you feel any additional testing is necessary, please indicate below. Please complete this form and then **FAX TO: 610-280-0797 as soon as possible.** Thank you.

_____
Surgeon, Vision One Laser & Surgery Center

Patient's Name _____ Surgery Date _____
Diagnosis Cataract ☐ Right Eye ☐ Left Eye
Proposed Surgery Cataract removal with lens implantation

Significant Past Medical History _____

Current Medications

Allergies

B/P _____/_____ Pulse _____ Resp. _____ Weight _ Ht._____
Heent _____
Lungs _____
Cardio-Vascular _____ EKG Interp._____
Abdomen _____
Extremities:
Neuro/Psych _____
Medical Diagnoses _____
Medical Condition Acceptable for Proposed Procedure ❑ Yes
For Patients Under 18 Years Of Age: Patient May Be Cared For In A Free-Standing Ambulatory Surgery Center ❑ Yes
Remarks _____

Physician Name and Address *(Print or Use Stamp)*

_____
Physician's Signature Date

AFFIX PATIENT LABEL HERE

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 ____
Do you smoke: N Y____ /Packs/Day _____
Do you drink alcohol? N Y ___ How much? _____
Do you do recreational drugs? N _____ Y _____
Could you be pregnant? N _____ Y _____
LMP _____

Have you ever had a problem with anesthesia or with Malignant Hyperthermia? N Y _____

Has anyone in your family had a problem with anesthesia or Malignant Hyperthermia? N Y _____

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication & Dosage	**times/day**	**Last Taken**	**Medication & Dosage**	**times/day**	**Last Taken**
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**
For None Check Here				
SUBSTANCE, e.g. latex, tape, IV dye	**Reaction**	**Severity**	**Date First Occurred**	**Last Exposure**
For None Check Here				

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

PATIENT SIGNATURE: _____ DATE: _____

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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

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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:
  - o One by the surgery center for use of the facilities
  - o One by your surgeon
  - o 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
  - o Does **NOT** include surgeon's fee
  - o Does include surgery center fee
  - o Does include anesthesia fee
  - o Does include fee for a standard lens
  - o **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**:
  - o 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.
  - o 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.