Office of Madhu Agarwal MD

Neuro-Ophthalmology, Oculoplastic, and Orbital Surgery, Adult Strabismus

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www.myeyelidsurgeon.com

We are eager to help provide the safest outpatient surgery environment for your patient:

_____

Target date:

_____

Kindly provide the following at least 30 days (but no earlier) prior to your patient's surgery:

- HISTORY AND PHYSICAL
- COMPLETE METABOLIC PANEL
- COMPETE BLOOD COUNT
- PT, PTT
- EKG

Thank you for your assistance and effort!

History and Physical

Pre-operative Diagnosis: _____

Chief Complaint/Extended History of Present Illness: _____

_____

Indications for Procedure/Surgery: _____

Proposed Procedure (consent to read): _____

_____

Anesthesia Type Requested: ☐ General ☐ MAC ☐ Regional ☐ Sedation ☐ Local

Physical Examination:

Complete for all surgeries/procedures:			
System Review	**Normal**	**Abnormal/Explain**	**Current Medications:** ☐ None ☐ See Medication List
Heart/CV			
HEENT/face			
Respiratory			
Chest/breast/axilla			
Abdomen			
Musculoskeletal			
Back			
Extremities			
GI			
GU			
Skin			
Pelvic/Rectal			
Hematology/lymphatic/ immunology			Allergies/Reactions: ☐ NKA
Neuro			
X-Ray findings			
Use drugs, alcohol, tobacco: ☐Yes ☐ No If yes, list: _____ Other relevant: ☐Yes ☐ No, If yes, list: _____ _____			Past major illnesses/injuries: ☐Yes ☐ None If yes, list: _____ _____ Age appropriate immunization status: ☐Received ☐ Not received: _____
Previous Surgeries/Hospitalizations:			Current Comorbid Conditions: ☐ None ☐ Yes/describe below

I have determined that this patient is a suitable candidate for the planned procedure at this facility. I have explained the procedure/surgery, including appropriate alternatives, benefits, side effects and risks. I have answered all the patient's/guardian's questions. The patient/guardian accepts the proposed procedural/surgical plan.

Physician Signature: _____ **Date:** _____ **Time:** _____

Complete This Section on Day of Service for History and Physical Performed within the Past 30 Days: (√ 1 box only)

☐ No change in patient condition noted after patient examination & review of H&P and admission patient history. I have determined that this patient is a suitable candidate for the planned procedure at this facility today.

☐ Change in patient condition noted after patient examination & review of H&P and admission patient history:
Describe: _____

Physician Signature: _____ **Date:** _____ **Time:** _____

Hoag Newport Center Surgicare
1441 Avocado Ave Ste 100
Newport Beach CA 92660

STEPS YOU NEED TO DO BEFORE YOUR SURGERY:

1) CALL TO PRE-REGISTER

   (949) 764-8424

2) Please fill out the page health history forms attached and bring it with you the day of surgery

HOAG HOSPITAL USE ONLY:

☐ *FAX to Pharmacy after admit physician signs*

PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information. **BRING THIS FORM WITH YOU TO HOAG.**

☐ *Check this box if not on any home medications.*

[Signature of Patient/Responsible Person]

DESCRIBE ALLERGIES & REACTIONS:

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit: Continue or Formulary Equivalent (circle one)		Medication	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete	On Discharge: Stop	On Discharge: Continue (Next Dose)
Y	N	1.							
Y	N	2.							
Y	N	3.							
Y	N	4.							
Y	N	5.							
Y	N	6.							
Y	N	7.							
Y	N	8.							
Y	N	9.							
Y	N	10.							

Medication Reconciliation on Entry:

_____ [Physician Signature]

Date/Time: _____ ID#: _____

DATE TIME T/O FROM SIGNATURE/TITLE

Noted: ☐ CC/RN: _____ Date/Time: _____

☐ RN: _____ Date/Time: _____

Medication Reconciliation on Discharge:

_____ [Physician Signature]

Date/Time: _____ ID#: _____

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

Medication	Dose	Route	Freq	Reason	Special Instructions	Medication Schedule	Comments:

Original to patient on discharge. Line through stopped meds.

Discharge RN: _____

Date/Time: _____

Discharge Physician Signature: _____

Date/Time: _____ ID#: _____

DATE TIME T/O FROM SIGNATURE/TITLE

MEDICATION RECONCILIATION/ORDERS

Hoag Memorial Hospital Presbyterian

PS 7514 Rev 12/16/10

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

Page ____ of ____ Patient Name _____

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____ Stated Weight: _____

Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No For which language? _____

Telephone #'s: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Contact Person: _____ Contact Phone Number: ( ) _____

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Internist/PCP: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Cardiologist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

Other Specialist: _____ Last Visit: _____ Next Visit: _____ Prior to Surgery? ☐ Yes ☐ No

ALLERGIES AND PREVIOUS SURGERIES

Allergies Title	Reaction

Previous Surgery Details	Surgery Year	Anesthesia Used

Please indicate if you have had any of the following CARDIAC/MEDICAL procedures listed below:

Angioplasty: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No Stent Placed? ☐ Yes ☐ No

Echocardiogram: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Stress Test: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker Brand: _____ Pacemaker Model: _____

Other Procedure: _____

CARDIOVASCULAR

☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Heart Valve Problems
☐ Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs
☐ Arrhythmias, i.e., A-Fib
☐ Coronary Artery Disease
☐ High Cholesterol
☐ Cardiomyopathy
☐ Family History of Heart Disease
☐ History of DVT/PE
☐ Carotid Artery Disease
☐ Heart Attack
☐ Hypertension

Date of Heart Attack: _____ Date of Chest Pain: _____

[1508]