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PRE-OPERATIVE INSTRUCTIONS

Name of Patient: Epstein, Jeffrey

Name of Operation: _____

Operation Date: 03/15/17

Operation Time: 3pm Am / Pm Arrival Time: 2pm Am / Pm

NOTE: YOU MUST FOLLOW THE INSTRUCTIONS OUTLINED NEXT TO ANY CHECKED BOXES BELOW.

Call Elsa at [REDACTED] option 1, the BUSINESS DAY before surgery, to confirm surgery time.

You need pre-testing (blood tests, EKG, physical)
 Pre-testing will be done at Mount Sinai Hospital
 10 Union Square East on 14th Street, Suite 3 B, Third floor.
 Date of Pre-testing: ___/___/___ Time: ___:___ am / pm

If you are having pre-testing at your private physicians office:
 Please fax the results to: Attn: Elsa [REDACTED] or [REDACTED]
 Have pretesting done:
 as soon as possible
 within 2 weeks of surgery date
 within 30 days of surgery date

Your child needs medical clearance from their pediatrician:
 Please fax the results to: Attn: Elsa [REDACTED] or [REDACTED]
 Have pretesting done:
 as soon as possible
 within 2 weeks of surgery date
 within 30 days of surgery date

Labs Only
 Please fax the results to: Attn: Elsa [REDACTED] or [REDACTED]
 Have labs done:
 as soon as possible
 within 2 weeks of surgery date
 within 30 days of surgery date

- You **DO NOT** need pre-testing

② You are having **Ambulatory Surgery**, which means you will be going home after your surgery. You **MUST** have someone escort you home. Please ask a friend or family member to accompany you home. If you do not have an escort the surgery will be **CANCELED**.

- You are **DAS**, which means you are staying overnight in the hospital.

② Please review the following:

1. Wear loose clothing for surgery
2. **DO NOT** wear any jewelry
3. **REMOVE** nail polish
4. Please shower normally the night before or morning of surgery.
5. Avoid using lotions, powders, and perfumes the night before and day of surgery

② **DO NOT** have anything to eat or drink after midnight the night before your operation. **NO Breakfast.**

This means **NO water, coffee, tea, juice, milk, and chewing gum. If you take any prescribed medication, discuss them with the doctor before surgery.**

If you must take medications in the morning, you may do so with a Sip of water. Please discuss these medications with the doctor before surgery.

② **DO NOT** take any aspirins or aspirin-containing products for a period of 1-2 weeks prior to your surgery.

For pain relief use Tylenol **ONLY during the two weeks before and after surgery.**

If you are on coumadin or other blood-thinning medications please discuss them with Dr. Ting, to determine when to stop these medications.

Surgery Locations:

- **On the day of your surgery please arrive 2 hours before your surgery time and go to:**

Ambulatory Surgery Unit Guggenheim Pavilion

1468 Madison Ave. (100th St.) 2nd fl

New York, NY 10029

212-241-7778

-OR-

1190 5th Ave. 2nd fl

New York, NY 10029

212-241-7778

- ☐ **On the day of your surgery please arrive 1 hour before your surgery time and go to:**

Mount Sinai Surgical Associates Ambulatory Surgery

5 East 98th St 14th fl. (double doors)

New York, NY 10029

212-241-0082

- **On the day of your surgery please arrive 2 hours before your surgery time and go to:**

Mount Sinai Beth Israel

16th Street & 1st Avenue 1st, Admitting department in the lobby

New York, NY 10025

(212) 212-420-4557

(The OR nurses will call you the day before surgery between 2-5pm to tell you what time to go to the hospital and other important information. If you surgery is scheduled for a Monday, the nurse will call you the Friday before. If ██████ like you may call them the day before your surgery, after 3pm at the number above)

- **On the day of your surgery please arrive 2 hours before your surgery time and go to:**

Staten Island University Hospital

475 Seaview Ave.

Staten Island, NY 10305

(718) 226-9000



The Mount Sinai Hospital
5 East 98th Street, 14th Floor,
New York, New York 10029

Patient: Epstein, Jeffrey
 [Redacted]: 01/20/53
 PLEASE FAX BACK WITH RESULTS TO:
 ELSA OR ALICIA [Redacted] and
 [Redacted]
 TELEPHONE: 212-241-4278 or
 212-241-8512

PRE - PROCEDURE HISTORY & PHYSICAL EXAMINATION

PATIENT HISTORY

Proposed Procedure(s):

Chief Complaint/History of Present Illness:

Past Medical History:

Past Surgical History:

Social/Occupation History:

Substance Use: Tobacco: Alcohol: Other:

Last Menstrual Period:

Allergies

Medications / Herbals

PHYSICAL EXAMINATION

Head/Eyes/Ears/Nose/Throat/Airway:

Cardiovascular:

Pulmonary:

Abdominal:

Extremities:

Neurological:

Physiologic Data

Height: cm

Weight: kg

BP: mmHg

Pulse: /min

Resp: /min

Temp: °C

Note: Does this patient have bleeding tendency? Yes No

Vancomycin Justification: B-lactam Allergy Dialysis Patient Long-Term Care Facility MRSA in Patient MRSA Prevalence Chronic Wound Care

ASSESSMENT & PLAN

Name: Dictation #: Signature: Date: Time:

IMMEDIATE PREOPERATIVE REASSESSMENT

I have reviewed the prior evaluation documented above or the Epic [Redacted] completed within the last 30 days.
 I have re-examined and re-evaluated the patient immediately prior to the procedure and, unless otherwise indicated below,
 have found no significant changes in the patient's condition.

Significant change has been documented in the Medical Record

Name: Dictation #: Signature: Date: Time:

The Mount Sinai Hospital NY, NY
Admission Test Order Sheet

Epstein, Jeffrey
 DOB: 01/20/53

DATE
 NAME
 UNIT NO.
 SEX/DOB
 SERIAL NO.
 LOCATION
 PHYSICIAN
 SERVICE

Patient Name _____
Last First

Patient Address _____

 Tel. No. _____

Admission Date _____

Physician's Name _____

Height: _____ ft. _____ in. Weight: _____ lbs.

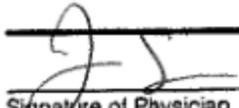
PHYSICIAN Check if requested	TEST	TECHNICIAN: Check when completed
<input checked="" type="checkbox"/>	EKG	<input type="checkbox"/>
<input type="checkbox"/>	"6 Tests" Blood Chemistry Only (Glucose, BUN & Electrolytes)	<input type="checkbox"/>
<input type="checkbox"/>	Medical Admissions For Me, PY, ND, GS, NU services (Includes "6 tests", patient monitoring (7) + uric acid)	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Surgical Admissions For all other services (Includes "6 tests", patient monitoring (7) = Cmp	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Complete Blood Count	<input type="checkbox"/>
<input type="checkbox"/>	Urinalysis	<input type="checkbox"/>
<input checked="" type="checkbox"/>	PT	<input type="checkbox"/>
<input checked="" type="checkbox"/>	PTT	<input type="checkbox"/>
<input type="checkbox"/>	Type and Cross-Match	<input type="checkbox"/>
<input type="checkbox"/>	Chest X-ray (PA) Other Chest X-ray (e.g. lateral, etc.). Please indicate: _____	<input type="checkbox"/> <input type="checkbox"/>
<input checked="" type="checkbox"/>	Pre-Operative History & Physical	<input type="checkbox"/>

Other tests:*
(see below)

On the specific request of an admitting physician, additional tests can be performed on the same specimen drawn for the new admission tests. The additional tests will be completed on a routine basis. Please PRINT below those tests you wish to order.

OTHER HEMATOLOGICAL TESTS:

OTHER CHEMISTRY TESTS:


 Signature of Physician _____
 Date 02/23/17

Blood Drawn By _____
 Time/Date Blood Drawn _____

* Please note that Hematology, Chemistry and Microbiology test results are available on the Laboratory Information System. Results can be retrieved by terminal inquiry or by calling the LABORATORY INFORMATION INQUIRY DESK, x-4LABS.
 Other laboratories will be added to the Laboratory Information System in the near future. Please do not order another specimen for repeat testing if you do not see your order on LIS. You may inquire whether the test has been performed by calling x-4LABS. Some laboratories are not on LIS and the results cannot be retrieved by terminal access.