Monticello Community Surgery Center Registration Information

Personal Information

Have you had any previous surgeries at this location? ☐ Yes ☐ No

Are you presently residing in a Skilled Nursing Facility? ☐ Yes ☐ No

Last Name:_____ First Name: _____ Middle Initial: _____

Maiden or Previous Name:_____ Date of Birth (MM/DD/YYYY):_____

SSN:_____ Sex: Male, Female Race: _____ Marital Status: _____

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address: _____

☐ Check here if you do not wish to receive emails from MCSC. We will never sell, share, or distribute your personal information, except the information needed to communicate with your insurance company.

Do you have an advanced medical directive? ☐ Yes ☐ No

Would you like information about medical directives? ☐ Yes ☐ No

Emergency Contact

Name:_____ Daytime Phone: _____ Cell Phone:_____

Employment Information

Occupation_____ Employer:_____

Employer's Mailing Address: _____ Phone: _____

City:_____ State:_____ Zip:_____

Insurance Information

Primary Insurance Company Name:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Subscriber's Relationship to Patient: _____

Secondary Insurance Company Name:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Subscriber's Relationship to Patient: _____

Monticello Community Surgery Center

CONSENT FOR PROCEDURE

1. I hereby authorize Dr. _____and/or such assistants as he/she may select to perform the following surgical procedure(s). I understand the proposed procedure to be: (right)____ (left)____

   Procedure(s): _____

   _____

2. It was explained to me there may be other physicians or qualified medical professionals who are not physicians who may perform part(s) of the operation or procedure as delegated by my physician. They will only be performing tasks within the scope of practice for which they have been granted privileges by MCSC.

3. I acknowledge by my signature below that the nature of my condition, need to treat (including further diagnosis and any needed photographs) such condition, procedure(s), and possible side effect, complications, and risks associated with the procedure(s), and possible alternatives to the procedure(s) have been explained to my satisfaction by the above named physician. The risks, which can be serious, include bleeding, infections and damage to nearby tissues, vessels, nerves or organs. The procedure may result in paralysis, cardiac arrest, brain damage and/or death. Other risks may include, but are not limited to

   _____

4. It has been explained to me and I understand that during the course of the procedure(s), unforeseen conditions may be revealed or urgent situations may arise that necessitate an extension of the original procedure, or additional or different procedure(s) than those set forth in paragraph #1 above. I therefore, authorize and request that the above named physician, his/her assistants, and his/her designees, perform such extension, additional or different procedure(s) which in his/her professional judgment are necessary or desirable.

5. I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

6. I agree that any tissues and/or body fluids removed during the course of the procedure may be examined, documented, preserved and/or disposed of in whatever manner may be considered proper for the purpose of diagnosis, study and advancement of medical knowledge.

7. I release Monticello Community Surgery Center's contracted laboratory, its employees and agents from any claims that may arise in connection with damage to any tissues or body fluids in delivery or by the receiving party, provided that reasonable care in the selection of a delivery system has been exercised.

8. I authorize surgical product representatives to be present during my procedure(s) when my surgeon deems it would be of assistance to the procedure(s) he/she is undertaking. I authorize professional health care students, volunteers, and other designated observers to be present but not participate in my care unless under direct supervision of MCSC staff.

9. I acknowledge that all blank spaces of this document have been either completed or crossed off prior to my signing.

10. I consent to be transported to Martha Jefferson Hospital or the University of Virginia Health System via ambulance; in the event an emergency situation arises that necessitates hospitalization for the further treatment/care/or evaluation.

11. I acknowledge that I have read the consent form (or has been read to me) and have had the opportunity to ask questions and were answered to my satisfaction.

_____ _____ _____

Signature of Patient or Person Authorized to Consent for Patient | Date of Informed Consent | Time of Signature

_____

Printed Name of Person Signing Above

_____

Signature of Surgeon

Witness _____ Relationship _____

_____ Patient label

Patient Name Printed by Physician Office

Monticello Community Surgery Center - H&P and Orders Form

Pre-Operative History and Physical

See primary care physician H&P ☐

See office note ☐

Name:_____

Chief Complaint:_____

PreOperative Diagnosis:_____

History of Present Illness: _____

Past Medical History:_____

_____

Previous Surgeries:_____

Present Medications:_____

ALLERGIES:_____

	Normal	Abnormal	Not Examined	Describe Abnormal and Pertinent Negatives
General				
HEENT				
Neck				
Heart				
Lungs				
Abdomen				
Rectal/Genital				
Musculoskeletal				
Neuro				

☐ Patient medically cleared for surgery at Monticello Community Surgery Center

Physician:_____ Date:_____

Pre-Operative Medication and Physician Orders

See Standing Orders ☐

Signature:_____ Date:_____

Post-Operative Orders and Notes:

Procedure:_____

Post-Operative Diagnosis:_____

Findings/Complications/Notes:_____

See dictated operative note ☐

ORDERS: **See Standing Orders ☐**

Resume routine home medication regimen as stated by patient on admission ☐

Discharge when criteria met ☐

Signature:_____

Revised 9/19/11

Patient Label

Anesthesia Pre-Operative Questionnaire

Patient Name	Sex	Age	Height	Weight

Yes No

☐ ☐ Previous surgery/anesthesia? List what & when _____

☐ ☐ Have you, or a blood relative, had any problems with anesthesia, including: nausea, weakness, difficulty breathing or high fever? If yes, explain: _____

☐ ☐ Do you have an advanced medical directive?

☐ ☐ Would you like information about medical directives?

For Children under age 18:

Yes No

☐ ☐ Premature birth

☐ ☐ Breathing problems after birth

☐ ☐ Other conditions being treated for: _____

_____

Yes No

☐ ☐ Heart problems after birth

☐ ☐ Respiratory illness in the past month

☐ ☐ Family history of muscle disease

For Ages 18 and Older:

Yes No

☐ ☐ Heart attack–when _____

☐ ☐ Heart surgery-If yes, what & when _____

_____

☐ ☐ Pacemaker/internal defibrillator

☐ ☐ Congestive heart failure

☐ ☐ Angina/chest pain

☐ ☐ Heart murmur requiring treatment

☐ ☐ Irregular heartbeat

☐ ☐ Last EKG: when & where_____

☐ ☐ High blood pressure

☐ ☐ Elevated cholesterol

☐ ☐ Fainting spells

☐ ☐ Shortness of breath

☐ ☐ Asthma/wheezing

☐ ☐ Emphysema/chronic bronchitis or/lung disease

☐ ☐ Have you ever had a Sleep Study

☐ ☐ Been told you stop breathing while you sleep

☐ ☐ Frequent morning headaches

☐ ☐ Fall asleep easily during the day

☐ ☐ Have you been diagnosed with Sleep Apnea

☐ ☐ Been prescribed CPAP/BiPAP machine

☐ ☐ Do you use the CPAP/BiPAP machine

Setting _____

☐ ☐ Do you snore loudly

☐ ☐ Back/neck surgery or problems

☐ ☐ Arthritis requiring treatment

☐ ☐ Problems opening mouth (TMJ)

☐ ☐ Numbness/weakness of muscles-If yes, where

_____

Yes No

☐ ☐ Chronic pain

☐ ☐ Thyroid disorder

☐ ☐ Stroke – when _____

☐ ☐ Seizures – type _____

☐ ☐ Frequent heartburn, hiatal hernia, reflux

☐ ☐ Diabetes/glucose intolerance

average morning blood sugar _____

☐ ☐ Bleeding problems/blood clots

☐ ☐ Family history of blood clots

☐ ☐ Sickle cell disease or trait

☐ ☐ Hepatitis or jaundice

☐ ☐ Cancer – of what & when_____

☐ ☐ Kidney disease/dialysis

☐ ☐ Mediport, portacath, vein shunt

☐ ☐ Prosthesis/implants _____

☐ ☐ Body piercings/jewelry

☐ ☐ A communicable disease (i.e., TB, HIV, VD, Hepatitis, MRSA, VRE)

Type _____

☐ ☐ Are you pregnant? Last menstrual period _____

☐ ☐ Are you currently taking birth control pills?

☐ ☐ Tobacco products: what/how often: _____

_____

☐ ☐ Vaping products: what/how often: _____

☐ ☐ Ever smoked in the past? If yes, quit when? _____

☐ ☐ Drink alcohol regularly/how much? _____

☐ ☐ Object to blood transfusions

☐ ☐ Dentures/partials/loose or chipped teeth

☐ ☐ Other conditions being treated for _____

_____

What is the most activity you can do before you get tired or short of breath and have to stop?

☐ Walk across room ☐ Walk one block ☐ Walk one mile ☐ Run a mile

If one block or less, what limits your activity? _____

Any other information you feel the anesthesiologist should know? _____

MONTICELLO
COMMUNITY SURGERY CENTER

Patient Label

Monticello Community Surgery Center

Patient Label

Medication Reconciliation Record

TO BE COMPLETED BEFORE SURGERY: Patient's medication list (patient or family to complete)

Patient Name:_____ **Date list written:**_____

Please Circle: Information provided by: **Patient** **Family** **Other** _____

ALLERGIES: ☐ **Denies** ☐ **Latex Sensitivity Reaction:**_____

Meds/Foods/Dyes/Other	Reaction	Meds/Foods/Dyes/Other	Reaction

Include all prescription medicines, over-the-counter medicines, herbal supplements, dietary supplements, vitamins, drug patches, eye drops, etc. taken by the patient.

☐ **Fill in this section only- please PRINT** ☐ **Refer to Patient's attached Medication list**

Medication Name	Dose (Amount Taken)	Frequency (How Often)	Route (How Taken)	What do you take this for?	Staff Use Only SPECIAL INSTRUCTIONS If Needed, this will be completed and initialed by surgery center staff

TO BE COMPLETED AFTER SURGERY:

After your surgery, **CONTINUE** all of your medications as you have been taking them unless there are special instructions written above. **IF** new medications are prescribed, they are listed below.

The treating physician has not altered your routine home medication regimen provided on your admission, unless specifically indicated. For your safety, please review this information with your personal physician as part of your follow-up.

Patient's representative's signature: _____ Date:_____

Nurse's signature:_____ Date:_____

TAKE THIS LIST WITH YOU TO ANY FUTURE DOCTOR APPOINTMENTS OR TESTS

Your Rights & Responsibilities as a Patient at the Monticello Community Surgery Center

The Staff at the Monticello Community Surgery Center pledge to do their personal best to provide our patients, patient representatives or surrogates, and their families with the highest quality of care and excellent service in providing services for outpatient surgical procedures.

In addition, each patient (patient representative or surrogate) has the right to the following:

- Receive respectful and safe care by competent personnel
- Be informed of patient rights during the admission process
- Be informed in advance about care and treatment and the related risks
- Make informed decisions regarding care and treatment and to receive information necessary to make those decisions
- Refuse care and treatment and to be informed of the medical consequences of refusing such
- Formulate advance directives
    - ✓ The patient who has an Advance Directive must provide a copy to MCSC. However, in the event the Advance Directive includes a "Do Not Resuscitate" (DNR) directive, the patient will be informed that the DNR directive will be suspended while at the Center. If indeed a need did arise, the Center will try any life saving measure to stabilize the patient and arrange for immediate transfer to a nearby hospital. When transfer to a hospital is required, the Advance Directive will be transferred with you and honored by the hospital.
    - ✓ If a patient does not have an Advance Directive, an official Virginia Advance Directive form may be requested from the Center by calling 434-293-4995 or by inquiring at the time of registration. Information relating to Advance Directive option under Virginia state law is provided on the reserve side of this page.
- Personal privacy and confidentiality of medical records
- Be free from abuse, neglect and exploitation
- Access information contained in his/her medical record within a reasonable time when requested; Access information regarding facility fees or payment information
- Receive health clinic services without discrimination based upon race, color, religion, gender, national origin or payer. Health clinics are not required to provide uncompensated or free care and treatment unless otherwise required by law.
- Monticello Community Surgery Center does provide charity care when certain conditions are met.
- Be informed if his/her surgeon is one of the several community physicians that have ownership in the Center by noting the disclosure on their Consent to Procedure form, calling the Center to directly inquire, or by reading the list of owners posted at the Center.
- Voice complaints and grievances without discrimination or reprisal. You may call Andy Poole, CEO, at (434) 971-3421, submit a letter, or use the satisfaction survey to express your concerns. You can expect a response from the CEO, by telephone, within 48 hours from the time of receipt of complaint. Written follow-up will be sent to the patient within 30 business days.

You may also file a complaint about your health care with the Virginia Department of Health. Complaints may be submitted in writing to the Virginia Department of Health, Office of Licensure & Certification, 9960 Mayland Drive, Suite 401, Henrico, VA 23233-1485, by telephone (800) 955-1819, fax, email, or in person. You may download a complaint form and read other information about filing a complaint at: http://www.vdh.state.va.us.

If you are a Medicare beneficiary you may also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to ask questions, and to submit complaints about the Monticello Community Surgery Center directly to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048.

Patient Responsibilities

All patients and their families are considered to be participating members of the health care team and are expected to take an active role in their care and treatment to the extent they are able. Each patient has specific rights to which they are entitled and the following responsibilities:

- To provide a complete list of medications including over the counter medications and supplements.
- To communicate their needs clearly to their health care providers.
- Be considerate of other patients and the personnel of the Center.
- Assist in the control of noise, smoking, and other distractions. The patient and their family are responsible for the respect of property of others and the Center.
- To report whether or not he/she clearly understands the planned course of treatment and what is expected of them.
- To disclose any information that may be necessary in the planning or management of their care.
- For keeping appointments and, when is unable to do so for any reason, for notifying the Center and the physician.
- For following instructions regarding medications, pre or post procedure instructions, and asking questions should they arise.
- For promptly fulfilling his or her financial obligations to the Center.
- To be knowledgeable about their coverage and benefits by third party payers and the necessary requirements of their policy. This includes all pre-certification or pre-authorization for procedures.
- To provide the Center with accurate and complete information necessary for billing and processing claims.
- To promptly report any complication to their physician in a timely manner. If after hours, to promptly call or go by the nearest emergency department.
- To return the Patient Satisfaction Survey to assist in ongoing quality of care.

Virginia Laws Regarding Advance Directives

Advance Directives are legal documents that allow you to state what you want for your own medical care if you are unable to make decisions for yourself.

§54.1-2984. Suggested form of written advance directives.

An advance directive executed pursuant to this article may, but need not, be in the following form, and may (i) direct a specific procedure or treatment to be provided, such as artificially administered hydration and nutrition; (ii) direct a specific procedure or treatment to be withheld; or (iii) appoint an agent to make health care decisions for the declarant as specified in the advance directive if the declarant is determined to be incapable of making an informed decision, including the decision to make, after the declarant's death, an anatomical gift of all of the declarant's body or an organ, tissue or eye donation pursuant to Article 2 (§32.1-289.2 et seq.) of Chapter 8 of Title 31.1 and in compliance with any directions of the declarant. Should any other specific directions be held to be invalid, such invalidity shall not affect the advance directive. If the declarant appoints an agent in an advance directive, that agent shall have the authority to make healthcare decisions for the declarant as specified in the advance directive if the declarant is determined to be incapable of making an informed decision and shall have decision-making priority over any individuals authorized under §54.1-2986to make health care decisions for the declarant. In no case shall the agent refuse or fail to honor the declarant's wishes in relation to anatomical gifts or organ, tissue or eye donation.

§54.1-2983 (For contingent effective date – see Editor's note) Procedure for making advance directive; notice to physician. Any competent adult may, at any time, make a written advance directive authorizing the providing, withholding, or withdrawal of life –prolonging procedures in the event such person should have a terminal condition. A written advance directive may also appoint an agent to make health care decisions for the declarant under the circumstances stated in the advance directive if the declarant should be determined to be incapable of making an informed decision. A written advance directive shall be signed by the declarant in the presence of two subscribing witnesses. A written advance directive may be submitted to the Advance Health Care Directive Registry, pursuant to Article 9 (§54.1-2994 et seq.) of this chapter. Such directive shall be notarized before being submitted to the registry.

Further, any competent adult who has been diagnosed by his attending physician as being in a terminal condition may make an oral advance directive to authorize the providing, withholding or withdrawing of life-prolonging procedures or to appoint an agent to make health care decisions for the declarant under the circumstances stated in the advance directive if the declarant should be determined to be incapable of making an informed decision. An oral advance directive shall be made in the presence of the attending physician and two witnesses.

It shall be the responsibility of the declarant to provide for notification to his attending physician that an advance directive has been made. If an advance directive has been submitted to the Advance Health Care Directive Registry pursuant to Article 9 of this chapter, it shall be the responsibility of the declarant to provide his attending physician, legal representative, or other person with the information necessary to access the advance directive. In the event the declarant is comatose, incapacitated or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of an advance directive and, if applicable, the fact that is has been submitted to the Advance Health Care Directive Registry. An attending physician who is so notified shall promptly make the advance directive or a copy of the advance directive, if written, or the fact of the advance directive, if oral, a part of the declarant's medical records.

(1983, c. 532, § 54-325.8:3; 1988, c. 765; 1992, cc. 748, 772; 1997, c. 801; 2008, cc. 301, 696.)

§ 54.1-2988. Immunity from liability; burden of proof; presumption.

A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of issuing a Durable Do Not Resuscitate Order or the withholding or the withdrawal of life-prolonging procedures under authorization or consent obtained in accordance with this article or as the result of the provision, withholding or withdrawal of ongoing life-sustaining care in accordance with § 54.1-2990. No person or facility providing, withholding or withdrawing treatment or physician issuing a Durable Do Not Resuscitate Order under authorization or consent obtained pursuant to this article or otherwise in accordance with § 54.1-2990 shall incur liability arising out of a claim to the extent the claim is based on lack of authorization or consent for such action.

A person who authorizes or consents to the providing, withholding or withdrawal of ongoing life-sustaining care in accordance with § 54.1-2990 or of life-prolonging procedures in accordance with a qualified patient's advance directive or as provided in § 54.1-2986 or a Durable Do Not Resuscitate Order pursuant to § 54.1-2987.1 shall not be subject, solely on the basis of that authorization or consent, to (i)criminal prosecution or civil liability for such action or (ii) liability for the cost of treatment.

The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-prolonging procedures, or issuing, consenting to, making or following a Durable Do Not Resuscitate Order in accordance with § 54.1-2987.1 did not, in good faith, comply with the provisions of this article.

The distribution to patients of written advance directives in a form meeting the requirements of § 54.1-2984 and assistance to patients in the completion and execution of such forms by health care providers shall not constitute the unauthorized practice of law pursuant to Chapter 39 (§ 54.1-3900 et seq.) of this title.

An advance directive or Durable Do Not Resuscitate Order made, consented to or issued in accordance with this article shall be presumed to have been made, consented to, or issued voluntarily and in good faith by a competent adult, physician or person authorized to consent on the patient's behalf.

(1983, c. 532, § 54-325.8:8; 1988, c. 765; 1992, cc. 412, 748, 772; 1998, cc. 803, 854; 1999, c. 814; 2000, cc. 590, 598.)

§ 54.1-2993. Reciprocity.

An advance directive executed in another state shall be deemed to be validly executed for the purposes of this article if executed in compliance with the laws of the Commonwealth of Virginia or the laws of the state where executed. Such advance directives shall be construed in accordance with the laws of the Commonwealth of Virginia.

(1992, cc. 748, 772.)