ATLANTA CENTER FOR FOOT & ANKLE SURGERY , LLC

Surgery Booking Sheet

Doctor's Name: DR. _____

Required Information		
Patient Name:	MRN:	DOB:
Phone #:	Weight:	BMI:
Insurance:	Self-Pay:	
Surgery Date:	Surgery Time:	Prep-op Appointment Date:
Do not enter DUMMY dates, if surgery date has not been confirmed use month and year as the date or TBD.	Est. Surgery Time:	Pre-op Time:

Anesthesia: ◯ Local ◯ MAC Sedation ☐ Nerve Block for Post-OP Pain

Will patient need Medical or Cardiac Clearance: YES ◯ NO ◯

Anesthesia Consult Requested: YES ◯ NO ◯

CPT Code	Procedure Description	Procedure Site	Diagnosis	ICD-10 Code
		Choose		
		Choose		
		Choose		
		Choose		
		Choose		

Implant and Equipment: Be sure to enter your request for equipment and implant needs below. This should include, Laser, Trauma drill, Screw drivers to remove hardware.

Implants:	**Equipment:**
K-wire: Smooth ☐ Threaded ☐ Size: _____ Screws: Cannulated ☐ Non-Cannulated ☐ Size: _____ Plate: _____ Anchors:	☐ C-Arm ☐ Laser ☐ Power set ☐ Trauma Drill
Other:	Other:
Vendor: Rep Name	PHONE:

Completed by: _____ Date: _____

Atlanta Center for Foot & Ankle Surgery, LLC
Implant Request Form

Surgery Date:	Time:	PO / Implant Log Number:
Patient Name:		Doctor:
Insurance:	CPT Codes:	ICD 10 Codes:

Please choose the following HCPS code for the implant being requested and obtain authorization:

☐ **L**8641 Metatarsal Joint Implant ☐ **L**8642 Hallux Implant ☐ **C-1713** Bone Anchor/Screw

☐ **L**8699 Prosthetic Implant not otherwise specified:

☐ Mid Foot ☐ Calcaneus ☐ Talus ☐ Lateral Malleolus ☐ Medial Malleolus

Authorization Obtained: ☐ N/A ☐ YES Date: _____ **Authorization Number:**

Available at Facility:

ANCHORS: **Arthrex** ☐ 2.2 mm ☐ 2.7mm ☐ 4.5mm ☐ 5.0 mm **Smith & Nephew**: ☐ 2.0mm ☐ 4.5mm **Biomet Juggerknot:** ☐ 1.4 mm ☐ 2.9 mm

BONE: ☐ Large Iliac Crest Wedge Life Link Cancellous Bone Chips 4 – 10 mm ☐ **15CC** ☐ **30 CC**

Synthes Screw Sets: ☐ 2.0 & 2.7- Mini Frag Set ☐ 2.4 Screw Set ☐ 3.5 & 4.0 - Small Frag Set ☐ Large Frag Set

Synthes Plates: ☐ Mini ☐ **1/3** Tubular w/collar ☐ **1/4** Tubular Please specify how many holes: _____

Trilliant Surgical: Cannulated Screws ☐ 2.0 mm ☐ 2.4 mm ☐ 3.0 mm ☐ 4.0 mm

Must be ordered:

Arthrex: ☐ Mini Scorpion ☐ Cannulated Screws ☐ **Headed** ☐ **Headless** ☐ 2.0 mm ☐ 2.5 mm ☐ 3.0 mm ☐ 4.0 mm

Flowers Orthopedics: ☐ 5th Met Fracture Kit ☐ Large Cannulated Screws: 6.0 mm

Flowers Orthopedics: ☐ Cannulated Screws: ☐ 2.0 mm ☐ 2.4 mm ☐ 3.0 mm ☐ 4.0 mm ☐ Lapidus Plate Kit ☐ Ankle Fracture Plate Kit

Smith & Nephew: ☐ VLP Plate System ☐ Cancellous Screws Size: _____ ☐ Cannulated Screws Size: _____ ☐ **Topaz Wand**

TS Surgical: Zimmer/ Biomet Cannulated Screws ☐ **Headed** ☐ **Headless** ☐ 2.0 mm ☐ 2.5 mm ☐ 3.0 mm ☐ 4.0 mm

Biomet Plating System ☐ Fore Foot Set ☐ Rear Foot Set ☐ Mid Foot Set

Trilliant Surgical: Headless Cannulated Screws: ☐ 2.0 mm ☐ 2.4 mm ☐ 3.0 mm ☐ Two-Step HT Implant ☐ HT Reamer Kit

Gridlock Plates: ☐ Mid Foot ☐ Fore Foot ☐ Ankle ☐ Disco Subtalar ☐ Twist Subtalar ☐ 3 S Hemi Implant

WRIGHT MEDICAL: ☐ Jones Fracture Screw ☐ 3.0 – 4.3 Cannulated Screws Darco Locking Plates: ☐ Fore Foot Set ☐ Rear Foot Set ☐ Fuse Force Staple

Headless Cannulated Screws : ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ Pro Toe Hammertoe Implant ☐ Swanson Implant

OTHER: (If not listed, enter item here):

THIS SECTION TO BE USED BY SURGERY CENTER

Vendor:		Rep Name:		Phone:
Date Received:	Date Ordered:	Date Confirmed:	Date Arrived:	Authorization Rec'd ☐ YES ☐ NO Auth #: _____

OR Nurse Verify Implants Used / STICKER:

RN Signature: _____ Date: _____

COPIES TO: 1- IMPLANTS FILE 2- CHART 3- CHARGE SHEET

Revised 03/06/2018

Atlanta Center for Foot & Ankle Surgery, LLC

Physician Pre-Op Orders

Patient's Name: _____ Date of Surgery: _____

Allergies: _____

1. Admit to Atlanta Center for Foot & Ankle Surgery under service of Dr. _____
2. Diagnosis: _____
3. Nerve Block for Post Op pain to be performed by Anesthesia: ☐ NO ☐ YES
4. Labs ordered: ☐ Yes ☐ No ☐ CBC ☐ U/A ☐ Chem Profile ☐ HCG

   Name of Lab: ☐ Lab Corp ☐ Quest Other: _____

   ☐ EKG If ordered where did the patient have the EKG: _____

   Perform at Surgery Center: ☐ Accu chek ☐ Urine Pregnancy Test
5. Anesthesia: ☐ IV Sedation / MAC

   ☐ Local Lidocaine: _____ Marcaine: _____
6. X-rays ☐ AP ☐ MO ☐ LO ☐ LAT ☐ Left ☐ Right ☐ Foot ☐ Ankle
7. Skin Prep: ☐ Prevail ☐ Betadine ☐ Hibiclens ☐ Other: _____
8. Pre-op Meds: ☐ Give 1 gram of Ancef 30 minutes prior to surgery.
   ☐ Give 2 grams of Ancef 30 minutes prior to surgery.
   ☐ Give 600mg of Cleocin 30minutes prior to surgery.

   Other Medications: _____
9. Other / Special Orders: _____
10. Instructions: ☐ Post op Surgery Instructions ☐ Wart Surgery ☐ Nail Surgery ☐ ESWT
11. Tourniquet: ☐ Yes ☐ No
12. Patient Position: ☐ Supine ☐ Lateral ☐ Prone
13. Bovie ☐ Yes ☐ No
14. Crutch Training: ☐ No ☐ Yes If yes, ☐ PWB ☐ NWB

_____DPM _____

Physician Signature Date

_____RN Completed: ☐ Yes ☐ No

Atlanta Center for Foot & Ankle Surgery, LLC

History & Physical

Patient Name: _____ **Physician:** _____ **Date:** _____

Chief Complaint: _____ **Date of Birth**: _____

Hx of Present Illness: _____

_____

_____

Past Medical Hx:

☐ Anemia	☐ Diabetes	☐ Pulmonary	☐ Seizures
☐ Cardiac Disease	☐ GI Disease	☐ Psycho/Social Hx	☐ Birth Comp.
☐ Coag. Problems	☐ Hypertension	☐ Renal Disease	☐ Growth/Develop
☐ CVA/TIA	☐ Liver Disease	☐ Surgical/Anesth. Comp.	☐ Immunization

Details of positive PMH: _____

_____

_____

Surgical Hx: _____

Current Medications: _____

Drug Allergies: ☐ **NKDA** _____

Social/Family Hx: _____ **EtOH**:_____ **Tobacco**:_____

Review of Systems:

HEENT:	☐ WNL	Abn: _____	GI:	☐ WNL	Abn: _____
Pulmon:	☐ WNL	Abn: _____	Integ:	☐ WNL	Abn: _____
Cardiovas:	☐ WNL	Abn: _____	Neuro:	☐ WNL	Abn: _____

Physical Exam:

Mental Status:	_____		Neck:	☐ WNL	Abn: _____
Lungs:	☐ WNL	Abn: _____	Heart:	☐ WNL	Abn: _____
Abd:	☐ WNL	Abn: _____	Neuro:	☐ WNL	Abn: _____
HEENT:	☐ WNL	Abn: _____	Other:	_____	

Lower Extremity Exam: _____

_____

_____

Radiographic Exam: _____

_____

Impression:/ Pre-Op Dx: _____

Plan: _____

Day of Surgery:

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

Changes: None List: _____

Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC

Request and Informed Consent to (Procedure or Diagnostic Test)

Do not sign this form until you have read it and fully understand its contents

Patient's Name: _____ Date: _____

The following has been explained to me in general terms and I understand that:

1) The diagnosis requiring this procedure is: _____

_____

_____

(Diagnosis described in layman's terms)

2) The nature of the procedure is: _____

_____

_____

(Describe in procedure in layman's terms)

3) The purpose of this procedure is: _____

_____

_____

(Specific for this patient)

4) **MATERIAL RISKS OF THIS PROCEDURE:**
As a result of this procedure being performed there may be material risk of: Infection, Allergic Reaction, Disfiguring Scar, Severe Loss of Blood, Loss or Loss of Function of Any Limb or Organ, Paralysis, Paraplegia or Quadriplegia, Brain Damage, Cardiac Arrest or Death.

5) In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to: stiffness, swelling, pain, numbness, difficulty wearing shoes, thickness of scar, recurrence of the original problem, delayed healing, and loosening of metal pins or screws if applicable. There may be other possible risks involved in this procedure including but not limited to: _____

_____

_____

6) The likelihood success of the above procedure is: ◯ Good; ◯ Fair; ◯ Poor;

7) Practical alternatives to this procedure include: _____

_____

8) If I choose not to have the above procedure, my prognosis (future medical condition) is: _____

_____

(to be filled in during informed consent process)

I understand that the physician, medical personnel, and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time consent is given. I consent to and authorized the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

(Initials _____Person Signing)

Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC

Patient Name: _____

I also consent to diagnostic studies, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissue, specimens, organs or limbs removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

The facility may participate in residency and other training programs for physicians, allied health professionals and other providers of services. All care rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel. I hereby consent to care and treatment from individuals in training and to the review of my patient record by same.

I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual (s) will not participate in the actual procedure.

I consent to the use of video-taping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research provided my name or identity is not revealed.

I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until directed by my physician.

I hereby permit the center to draw and test my blood for HIV or Hepatitis in the event of an accidental exposure by needle stick, splash, or scalpel injury etc. I understand and consent that the patient's as well as the affected individual will be tested (as appropriate). I further understand that the blood will not be routinely tested for these diseases, results of any testing will be kept confidential in the accordance with the state law, and my physician will notify me of any abnormal results.

I am aware that my physician may have an ownership interest in the facility, and I acknowledge that I have a right to have the procedure performed elsewhere.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form.

I hereby voluntarily request and give my consent to the performance of the procedures described or referred to herein by Dr. _____ D.P.M. and any other physicians or other medical personnel who may be involved in the course of my treatment.

_____ _____

Patient / Responsible Adult **Date / Time**

_____

Relationship to patient if not the patient / list reason

_____ _____

Witness **Physician Signature / Date**

SUBMIT FORM TO CENTER