

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: <input type="checkbox"/> Local <input type="checkbox"/> MAC Sedation <input type="checkbox"/> Nerve Block for Post-OP Pain Exparel Will patient need Medical or Cardiac Clearance: YES NO Anesthesia Consult Requested: YES NO				
CPT Code	Procedure Description	Procedure Site	Diagnosis	ICD-10 Code
		L R B		
		L R B		
		L R B		
		L R B		
		L R B		
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: K-wire: Smooth Threaded Size: _____ Screws: Cannulated Non-Cannulated Size: _____ Plate: _____ Anchors: _____			Equipment: <input type="checkbox"/> C-Arm <input type="checkbox"/> Laser <input type="checkbox"/> Power set <input type="checkbox"/> Trauma Drill	
Other: _____			Other: _____	
Vendor: _____			PHONE:	
Rep Name _____				

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:

<input type="checkbox"/> L8641 Metatarsal Joint Implant	<input type="checkbox"/> L8642 Hallux Implant C-1713 Bone Anchor/Screw
<input type="checkbox"/> L8699 Prosthetic Implant not otherwise specified:	
<input type="checkbox"/> Mid Foot <input type="checkbox"/> Calcaneus <input type="checkbox"/> Talus <input type="checkbox"/> Lateral Malleolus <input type="checkbox"/> Medial Malleolus	
Authorization Obtained: <input type="checkbox"/> N/A <input type="checkbox"/> YES Date: _____	Authorization Number:

Available at Facility:

ANCHORS: Arthrex <input type="checkbox"/> 2.2 mm <input type="checkbox"/> 2.7mm <input type="checkbox"/> 4.5mm <input type="checkbox"/> 5.0 mm Smith & Nephew: <input type="checkbox"/> 2.0mm <input type="checkbox"/> 4.5mm Biomet Juggerknot: <input type="checkbox"/> 1.4 mm <input type="checkbox"/> 2.9 mm
BONE: <input type="checkbox"/> Large Iliac Crest Wedge Life Link Cancellous Bone Chips 4 – 10 mm <input type="checkbox"/> 15CC <input type="checkbox"/> 30 CC
Synthes Screw Sets: <input type="checkbox"/> 2.0 & 2.7- Mini Frag Set <input type="checkbox"/> 2.4 Screw Set <input type="checkbox"/> 3.5 & 4.0 - Small Frag Set <input type="checkbox"/> Large Frag Set
Synthes Plates: <input type="checkbox"/> Mini <input type="checkbox"/> 1/3 Tubular w/collar <input type="checkbox"/> 1/4 Tubular Please specify how many holes: _____
Trilliant Surgical: Cannulated Screws <input type="checkbox"/> 2.0 mm <input type="checkbox"/> 2.4 mm <input type="checkbox"/> 3.0 mm <input type="checkbox"/> 4.0 mm

Must be ordered:

Arthrex: <input type="checkbox"/> Mini Scorpion <input type="checkbox"/> Cannulated Screws <input type="checkbox"/> Headed <input type="checkbox"/> Headless <input type="checkbox"/> 2.0 mm <input type="checkbox"/> 2.5 mm <input type="checkbox"/> 3.0 mm <input type="checkbox"/> 4.0 mm
Flowers Orthopedics: <input type="checkbox"/> 5 th Met Fracture Kit <input type="checkbox"/> Large Cannulated Screws: 6.0 mm
Flowers Orthopedics: <input type="checkbox"/> Cannulated Screws: <input type="checkbox"/> 2.0 mm <input type="checkbox"/> 2.4 mm <input type="checkbox"/> 3.0 mm <input type="checkbox"/> 4.0 mm <input type="checkbox"/> Lapidus Plate Kit <input type="checkbox"/> Ankle Fracture Plate Kit
Smith & Nephew: <input type="checkbox"/> VLP Plate System <input type="checkbox"/> Cancellous Screws Size: _____ <input type="checkbox"/> Cannulated Screws Size: _____ <input type="checkbox"/> Topaz Wand
TS Surgical: Zimmer/ Biomet Cannulated Screws <input type="checkbox"/> Headed <input type="checkbox"/> Headless <input type="checkbox"/> 2.0 mm <input type="checkbox"/> 2.5 mm <input type="checkbox"/> 3.0 mm <input type="checkbox"/> 4.0 mm Biomet Plating System <input type="checkbox"/> Fore Foot Set <input type="checkbox"/> Rear Foot Set <input type="checkbox"/> Mid Foot Set
Trilliant Surgical: Headless Cannulated Screws: <input type="checkbox"/> 2.0 mm <input type="checkbox"/> 2.4 mm <input type="checkbox"/> 3.0 mm <input type="checkbox"/> Two-Step HT Implant <input type="checkbox"/> HT Reamer Kit
Gridlock Plates: <input type="checkbox"/> Mid Foot <input type="checkbox"/> Fore Foot <input type="checkbox"/> Ankle <input type="checkbox"/> Disco Subtalar <input type="checkbox"/> Twist Subtalar <input type="checkbox"/> 3 S Hemi Implant
WRIGHT MEDICAL: <input type="checkbox"/> Jones Fracture Screw <input type="checkbox"/> 3.0 – 4.3 Cannulated Screws Darco Locking Plates: <input type="checkbox"/> Fore Foot Set <input type="checkbox"/> Rear Foot Set <input type="checkbox"/> Fuse Force Staple Headless Cannulated Screws : <input type="checkbox"/> 2.0 <input type="checkbox"/> 2.5 <input type="checkbox"/> 3.0 <input type="checkbox"/> Pro Toe Hammertoe Implant <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO Auth #: _____

OR Nurse Verify Implants Used / STICKER:

RN Signature: _____ Date: _____

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. Nerve Block to be performed by Anesthesia No Yes

3. Labs ordered: No Yes CBC U/A Chemical Profile HCG

Name of Lab: Lab Corp Quest Other: _____

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

4. Perform at Surgery Center: Accu chek Urine Pregnancy Test or Pregnancy Wavier

5. Anesthesia: MAC IV Sedation / Start IV Local Local w/ IV Start

6. Local Anesthetic: Exparel: _____ Lidocaine: _____ Marcaine: _____

7. Pre-op Meds: Give 1 gram of Ancef / Cefazolin within 60 minutes prior to surgery
 Give 2 grams of Ancef / Cefazolin within 60 minutes prior to surgery
 Give 600mg of Cleocin within 60 minutes prior to surgery

Other Medications: _____

7. Other / Special Orders: _____

8. DVT Pneumatic Compression: No Yes

9. Crutch Training: No Yes If yes, PWB NWB

10. Instructions: Post op Surgery Instructions Wart Surgery Nail Surgery

To Be Done in the OR:

11. Tourniquet: No Yes

12. Patient Position: Supine Lateral Prone

13. Skin Prep: Chloraprep Betadine Scrub/Paint

_____ DPM

Date: _____ Time: _____

_____ RN

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.

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