

## Request for Pre-Operative History and Physical

|                         |        |
|-------------------------|--------|
| Patient Name:           | DOB:   |
| Primary Care Physician: | Phone: |
| Surgery Date:           | Fax:   |

**Surgery Location:**

- ☐ Beacon Summit Surgery Center  
☐ Beacon West Surgery Center  
☐ Beacon Evendale Surgery Center  
☐ Other: \_\_\_\_\_

**Surgical Procedure:**

☐ \_\_\_\_\_ ☐ Right ☐ Left ☐ Bilateral

Dear Primary Care Physician:

I have recently evaluated the above mutual patient for their orthopaedic condition. After meeting with them and reviewing their medical situation, it has been determined that a surgical procedure is needed.

Please be informed that the patient is seeing you today because they are required to have a preoperative history and physical evaluation. I thank you in advance for accommodating them and ask that you please notify me as soon as possible should your examination yield any pertinent abnormalities or contraindications to surgery.

I will keep you informed of this patient's progress and plan of care. Please contact our office at (513) 354-3700 should you have any issues or concerns with regard to this patient.

**Please Note:** If your patient is over the age of 50, or has a cardiac history, an EKG is required within 90 days for surgical clearance.

**Please fax the completed H&P Form and all related diagnostics to:**

Beacon Surgery Center at: 513-823-2887 (Summit/West) | 513-854-9916 (Evendale)

Thank you!

Adam Abraham, M.D.

## Beacon Orthopaedics Surgery Center

fax # 513-823-2887 (Summit/West) | fax # 513-854-9916 (Evendale)

|                             |               |         |
|-----------------------------|---------------|---------|
| Patient:                    | Surgery date: | D.O.B.: |
| Surgeon: Adam Abraham, M.D. | Procedure:    |         |

### Medical History *(circle if applicable)*

1. Cold / Chronic Cough / Tuberculosis \_\_\_\_\_
2. Bronchitis / Emphysema / OSA \_\_\_\_\_
3. Asthma / Shortness of Breath \_\_\_\_\_
4. Rheumatic Fever / Heart Murmur \_\_\_\_\_
5. High Blood Pressure \_\_\_\_\_
6. Swelling of Feet / Fluid in Lungs \_\_\_\_\_
7. Heart Attack \_\_\_\_\_
8. Irregular, Fast Heartbeats \_\_\_\_\_
9. Bruises, Bleeding Easily \_\_\_\_\_
10. Sickle Cell Anemia / Anemia \_\_\_\_\_
11. Diabetic / Low Blood Sugar \_\_\_\_\_
12. Pregnant: No. of weeks \_\_\_\_\_
13. Kidney Disease \_\_\_\_\_
14. Jaundice / Hepatitis \_\_\_\_\_
15. Hiatal Hernia / Ulcer / GERD \_\_\_\_\_
16. Convulsions / Epilepsy / Stroke \_\_\_\_\_
17. Meningitis / Paralysis \_\_\_\_\_
18. Back Pain / Slipped Disc / Arthritis \_\_\_\_\_
19. Psychological Disease \_\_\_\_\_
20. Thyroid Disease \_\_\_\_\_
21. Glaucoma \_\_\_\_\_
22. Skeletal Deformities / Disease \_\_\_\_\_
23. Loose Teeth / Caps on Front Teeth \_\_\_\_\_
24. History Anesthesia Complications (Self/Family) \_\_\_\_\_
25. Cancer / Leukemia / HIV \_\_\_\_\_
26. Other: \_\_\_\_\_

Smoker: Pack / Day \_\_\_\_\_

Alcohol intake: \_\_\_\_\_

Drug Abuse: \_\_\_\_\_

Menstrual History: \_\_\_\_\_

Menopause: \_\_\_\_\_ Hysterectomy: \_\_\_\_\_

LMP: \_\_\_\_\_

### Assessment

HEENT: NOR / ABN \_\_\_\_\_

NECK: NOR / ABN \_\_\_\_\_

CHEST: NOR / ABN \_\_\_\_\_

HEART: NOR / ABN \_\_\_\_\_

ABDOMEN: NOR / ABN \_\_\_\_\_

EXTREM: NOR / ABN \_\_\_\_\_

### Previous Surgery: YES / NO

List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergies: YES / NO

List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medications: YES / NO

List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Provider Notes:

#### Special Notes:

\* H&H if 70 or older for general/spinal anesthesia

\* K if on Diuretics

\* EKG needed for 50 or older or cardiac history

Family History: \_\_\_\_\_

|           |               |               |           |           |             |
|-----------|---------------|---------------|-----------|-----------|-------------|
| VS: _____ | Height: _____ | Weight: _____ | BP: _____ | HR: _____ | Temp: _____ |
|-----------|---------------|---------------|-----------|-----------|-------------|

*By signing I agree the patient is medically cleared for surgery.*

|                           |             |             |
|---------------------------|-------------|-------------|
| Provider Signature: _____ | Date: _____ | Time: _____ |
|---------------------------|-------------|-------------|



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## Beacon Orthopaedics Surgery Center

### Pre-Operative Testing Orders

|                 |      |                            |
|-----------------|------|----------------------------|
| Patient's Name: | DOB: | Pre-Op Diagnosis (ICD-10): |
|-----------------|------|----------------------------|

Surgical Procedure: \_\_\_\_\_

## History and Physical

Must be completed within 30 days prior to surgery

## Required Lab Work

Must be completed for all patients within 30 days prior to surgery

- a. CBC with differential
- b. CRP
- c. PT/INR
- d. aPTT

## EKG

Required for all patients 50 years of age or older 90 days of surgery, or patients with a history of any cardiac disease (MI, angina, stent placement, or CABG etc.)

**Fax all testing plus history and physical to 513-823-2887 (Summit/West) | 513-854-9916 (Evendale)**  
**at least 48 hours prior to surgery date**

|                                                                              |                                                                                              |                                                                                             |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <b>Summit Surgical Center</b><br>501 E. Business Way<br>Cincinnati, OH 45241 | <b>Beacon West Surgical Center</b><br>6480 Harrison Avenue Suite 200<br>Cincinnati, OH 45247 | <b>Beacon Evendale Surgical Center</b><br>3155 Glendale Milord Road<br>Cincinnati, OH 45241 |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|

**Phone:** 513-257-2950/ 513-840-1001

**Fax:** Summit/ West 513-823-2887

Evendale: 513-854-9916

### Cardiac Risk Assessment for Ambulatory Surgery

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Procedure: \_\_\_\_\_

Type of Anesthesia: \_\_\_\_\_

Surgeon: Adam Abraham, M.D.

Date of Surgery: \_\_\_\_\_

Location: \_\_\_\_\_

Medications: Please indicate for how long the patient can hold their blood thinner:

Medication: \_\_\_\_\_

\_\_\_\_\_ I agree the patient can hold the above listed blood thinner for surgeon suggested amount of time.

\_\_\_\_\_ I suggest the above blood thinner be held for \_\_\_\_\_ days preoperatively. To be resumed \_\_\_\_\_ days postoperatively.

This section only applies to patients with AICD/Pacemaker:

Is the patient's device a: Pacemaker Implanted Cardiac Defibrillator Pacemaker/Defibrillator Combo

Does the device need to be interrogated after surgery: \_\_\_\_\_

Can a magnet be used during surgery: \_\_\_\_\_

Device manufacturer: \_\_\_\_\_

Device Serial Number: \_\_\_\_\_

Device Representative Name and Phone: \_\_\_\_\_

Location of the device (i.e. upper left chest): \_\_\_\_\_

Is the patient pacemaker dependent: \_\_\_\_\_

By signing this form, I agree this patient is an **ACCEPTABLE** candidate for **outpatient surgery** and same day discharge at an **ambulatory surgery center**:

Cardiologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Notes:

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### REQUEST FOR SURGICAL CLEARANCE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Surgeon: Adam Abraham, M.D. Phone: **513-257-2950/ 513-840-1001**

Surgery: \_\_\_\_\_ Fax: **513-823-2887 (Summit/West) | 513-854-9916 (Evendale)**

Surgery Date: \_\_\_\_\_ Location: \_\_\_\_\_

Anesthesia: \_\_\_\_\_ Duration: \_\_\_\_\_

I have recently evaluated the above mutual patient for their orthopedic condition. After meeting with them and reviewing their medical situation, it has been determined that the patient needs a surgical procedure. Before proceeding with the above-named procedure, the patient needs pre-surgical clearance.

\_\_\_\_\_ Patient is an acceptable candidate and is cleared for above orthopedic surgery from \_\_\_\_\_ standpoint for surgery at **outpatient surgery center with same day discharge.**

\_\_\_\_\_ Patient is not an acceptable candidate for surgery at outpatient surgery center with same day discharge.

Signature: \_\_\_\_\_ date: \_\_\_\_\_

Specialty: \_\_\_\_\_  
Please fax this form to **513-823-2887 (Summit/West) | 513-854-9916 (Evendale)**  
along with the last office visit and any testing within the last year.

## One Medical Passport Patient Quick Start Guide

Physician: Adam Abraham, M.D. Procedure Date: \_\_\_\_\_

Beacon Orthopaedics Surgery Centers, LLC asks that you complete pre-admission with One Medical Passport. The website guides you to enter your medical history online to help us to provide you with the best possible care and minimize long phone interviews and paperwork.

### Begin Pre-Admission on Our Website

Begin at our facility website: [www.beaconortho.com](http://www.beaconortho.com) and click on the **Services** link at the top of the page. Next, select **Surgery** from the right side of the page and select the **Online Pre-Registration** link, which will take you to the One Medical Passport home page shown below.

### Create Your One Medical Passport Account

First time users of onemedicalpassport.com should click the green **Register** button and create an account. Answer the questions on each page and click save and continue. Once complete, you will be prompted to click **Finish** to securely submit your information.

### First Time Website Users Click Register

Username you chose: \_\_\_\_\_

### Returning Users (for changes or reuse)

Enter the username and password you chose to access or update your account.



### Help Completing Pre-Admission

Each page has a **Help** link you may click for assistance. If you are unable to complete online pre-admission, please call during business hours for assistance.

**Summit and West:** 513-257-2950 **Evendale:** 513-840-1001

