

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!

Robert Raines, M.D.

Beacon Orthopaedics Surgery Center

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

Patient:	Surgery date:	D.O.B.:
Surgeon: Robert Raines, 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: _____
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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):
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Surgical Procedure: _____

History and Physical

Must be completed within 30 days prior to surgery

Required Lab Work

Must be completed within 30 days prior to surgery

Serum Potassium Level

- a. Patients receiving diuretics
- b. All renal failure patients (must be drawn following the last day of dialysis)
- c. Patients taking digitalis

Hemoglobin and Hematocrit (if receiving General or Spinal Anesthesia)

Required within 1 month prior to surgery for:

- a. Patients with a history of anemia, bleeding, or other hematologic disorders
- b. Patients with liver disease
- c. Patients 70 years of age or older

EKG

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

Additional Testing (ordered by PCP and/or anesthesiologist)

Chest X-Ray: Only if clinically indicated by changes in condition suggesting unstable cardiac or pulmonary condition.

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

Summit Surgical Center 501 E. Business Way Cincinnati, OH 45241	Beacon West Surgical Center 6480 Harrison Avenue Suite 200 Cincinnati, OH 45247	Beacon Evendale Surgical Center 3155 Glendale Milord Road Cincinnati, OH 45241
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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: Robert Raines, 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:

REQUEST FOR SURGICAL CLEARANCE

Patient Name: _____

Surgery Date: _____

DOB: _____

Surgery: _____

Surgeon: Robert Raines, M.D.

Location: _____

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

Anesthesia: _____

Fax: **513-823-2887 (Summit/West) |**

Duration: _____

513-854-9916 (Evendale)

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: Robert Raines, 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 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

