BEACON
Orthopaedics & Sports Medicine

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) I 513-854-9916 (Evendale)

Thank you!

Maria Rodenberg, M.D.

BEACON
Orthopaedics & Sports Medicine

Beacon Orthopaedics Surgery Center

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

Patient:	Surgery date:	D.O.B.:
Surgeon Maria Rodenberg, 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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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

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.)

Required Lab Work for Total Joint Replacement

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

a. CBC with differential
b. BMP
c. PT/ INR
d. aPTT
e. A1c if diabetic

Required Lab Work for Non-Total Joint Replacement

Serum Potassium Level

Required within 30 days prior to surgery for:

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 30 days prior to surgery for:

a. Patients 70 years of age or older

b. Patients with liver disease

c. Patients with a history of anemia, bleeding, or other hematologic disorders

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

BEACON
Orthopaedics & Sports Medicine

Phone: 513-257-2950/ 513-840-1001
Fax: Summit/ West 513-823-2887
Evendale: 513-854-9916

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Orthopaedics & Sports Medicine

Cardiac Risk Assessment for Ambulatory Surgery

Patient Name: _____DOB: _____

Procedure: _____
Type of Anesthesia:_____ Surgeon: Maria Rodenberg, 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: Maria Rodenberg, M.D._____

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

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

513-854-9916 (Evendale)

Surgery Date: _____

Surgery: _____

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: ___Maria Rodenberg, 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

ONE MEDICAL PASSPORT™