# RED LION SURGICENTER

PROVIDER DOCUMENTATION OF ADULT INCOMPETENCE TO CONSENT FOR TREATMENT

Patient Name: _____
Date of Birth: _____

Procedure(s): □ Oral Rehab □ _____

The Patient is 18 years of age or older and, based on knowledge of my observation and interaction with the patient, I do not believe that the patient is capable of understanding the anesthesia consent, the procedure(s), the risks of the procedure(s) and/or the alternatives to the procedure(s) to a sufficient degree to be able to give informed consent to the procedure(s). Therefore, the patient is currently incompetent and unable to give consent for the procedure(s). This determination of competency applies only with respect to the above procedure. A new determination of competency is required before any other non-routine procedures (e.g., surgery, blood transfusion, anesthesia, etc.) or if the patient's mental condition changes.

_____ _____ _____

Provider Signature | Printed Name | Date

# Preoperative Testing Requirements for Special Touch Patients at Red Lion Surgicenter

Patient's name: _____
Please fax results to 215-676-7130/215-676-2232

**BY DISEASE**

☐ **Bleeding Disorder, Anemia**

CBC + Platelets
PT/PTT

☐ **Cardiovascular Disease**

CBC + Platelets
EKG
Chest X-ray (if h/o CHF or valvular disease)

☐ Cardiology Consult if MI or unstable angina within 6 months, cardiac reason for ER visit or hospitalization within 6 months, h/o severe CHF, cardiomyopathy or valvular disease

☐ **Pulmonary Disease**

EKG
Chest X-ray (if severe lung disease or pneumonia/bronchitis within 3 months)

☐ **Diabetes Mellitus**

EKG
Electrolytes
BUN, Creat
Glucose

☐ **Hepatic Disease**

CBC + Platelets
PT/PTT
Electrolytes
BUN, Creat
Liver Profile

☐ **Renal Disease** **Rev.8/18**

CBC + Platelets
EKG
Electrolytes
BUN, Creat

☐ **Thyroid Disease**

TSH

☐ **Malignancy, Chemotherapy or Radiation Therapy**

CBC + Platelets
EKG
Electrolytes
BUN, Creat
Chest X-ray

**BY AGE**

☐ **Over 60 -** EKG

**BY MEDICATION**

☐ **Coumadin *** Check with Dr. who ordered Coumadin if OK to hold**

*Hold Coumadin 5-7 days pre-op
PT/PTT/INR day before surgery, run stat and faxed to RLSC at 215-676-7130

☐ **Digoxin**

EKG
Electrolytes
BUN, Creat
Digoxin Level

☐ **Aspirin** or **NSAIDS** hold for 7 days

☐ **Diuretics, ACE Inhibitors & other antihypertensive agents**

EKG
Electrolytes
BUN, Creat

Dr. _____NP!#_____

**RED LION SURGICENTER**
240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

# ADULT HISTORY AND PHYSICAL EVALUATION

*☞ This form is to be completed by your primary care physician. ☜*

This form must be completed and dated within 30 days prior to the date of surgery. Please complete this form and return it to the patient for forwarding to the Surgicenter or mail/fax the completed form to the address provided above. Thank you for participating in this patient's care.

Patient Name: _____ DOB:_____

Pre-Op Diagnosis: Multiple Carious Teeth; Acute Stress Reaction Proposed Procedure(s): Oral Rehab

Allergies: _____ Current Medications: _____

_____

PAST MEDICAL HISTORY (include pulmonary, cardiac, psych)_____

_____

PAST SURGICAL HISTORY_____

_____

PHYSICAL EXAM

HT:_____ WT:_____ AGE:_____ BP:_____ P:_____ R:_____

General Appearance:_____

| Check Box If No Significant Findings | Describe Abnormal Findings |
|---|---|
| ☐ HEENT | _____ |
| ☐ Lungs | _____ |
| ☐ Heart | _____ |
| ☐ GI/AB | _____ |
| ☐ GU | _____ |
| ☐ Back | _____ |
| ☐ Extremities | _____ |
| ☐ Neuro | _____ |

DATA (labs, EKG, etc.) EKG required in patients > 50 years old or with hypertension/heart disease

IMPRESSION (Please sign and date below)

I find this patient to be medically fit for the proposed procedure(s) and I agree that the patient is an appropriate candidate fro care at an ambulatory surgical center.

Signature:_____

Print/Stamp Name:_____

Date:_____ Phone:_____

Patient Label

# RED LION SURGICENTER

## DETERMINATION OF ALTERNATE CONSENT PROVIDER

**Patient Name:** _____

**Date of Birth:** _____

**Procedure(s):** □ **Oral Rehab** □ _____

The Patient is 18 years of age or older and is incapable of understanding the anesthesia consent, the procedure, the risks of the procedure and/or the alternatives to the procedure to a sufficient degree to be able to give informed consent. Therefore, consent must be provided by an alternate person.

**Name of Alternate Consent Provider**: _____

**Relationship**: □ Court-appointed legal guardian or POA (copies of court documents attached)

□ Designated health care agent or representative (facility director)

□ Family Member:

□ Spouse □ Adult child □ Parent □ Adult sibling □ Adult grandchild

□ Other: _____

The undersigned attests that the above alternate consent provider is legally responsible for the patient and able to give informed consent on the patient's behalf.

Signature: _____

Name: _____

# RED LION SURGICENTER

August 20, 2019

To Special Touch agencies

As you well know, healthcare policy is ever evolving and changing. As a licensed ambulatory care facility, the Red Lion Surgicenter strives to provide the best and safest care for our patients. In order to remain in compliance with state and federal guidelines, we have instituted a few changes in documentation that will be required for each Special Touch patient seen at the Red Lion Surgicenter beginning September 15 , 2019.

The consent forms are usually sent to be signed by the patient's POA/legal guardian and faxed or emailed to our office. **Emailed or faxed consents will no longer be accepted. This applies to the anesthesia and dental consent forms.** The PA Department of Health requires each patient to have the consent provider present to sign consent on the day of service **or** to have telephone verbal consents obtained by the provider prior to the day of service. The consent provider must provide a phone number where they can be reached by the dentist and anesthesiologist so consents can be obtained. The consents must also be witnessed by a separate individual (usually a nurse at RLSC who is available at time of consent authorization).

A "Determination of Alternate Consent Provider" form will be included with our scheduling paperwork to attest to the legality of the person who is giving consent for the procedure. This form, which can be filled-out by the patient's nurse consultant, attests to the fact that the person giving consent has the legal standing to do so in a court of law either because they are the POA or legal guardian. Preferably, the court documentation should be sent with the form. If unavailable, the person signing may attest to legal guardianship.

While these changes may seem cumbersome at first, please be assured that we have only the patient's safety and best interests in mind.

If you have any questions regarding these new forms and policies, please reach out to our Special Touch coordinator, the nursing staff, or the Director of Nursing.

Sincerely,

Josh Bresler, DMD

Medical Director

Jessica Coriano, Special Touch Coordinator P:215-676-2232 x22 (jessica@redlionsurgicenter.com)
Nursing Staff of Red Lion Surgicenter P:215-676-2232 x35
Kim Rickards, MSN,RN, Director of Nursing P:215-676-2232 x33 (krickards@redlionsurgicenter.com)

Attachments:
Determination of Alternate Consent Provider, Revised Anesthesia Consent Form

# SPECIAL TOUCH DENTISTRY

211 Geiger Road  Philadelphia, PA 19115  (215) 508-4200

Special Touch DENTISTRY

Thank you for choosing Special Touch Dentistry. This packet contains all of the necessary paperwork for dental care to be performed in a special clinical environment. The information in this packet is specifically detailed, because this level of care requires that our staff completely understands the medical, pharmacological, dental and behavioral status of a patient *before* we can provide treatment.

**Who Fills Out What?**

Please read all of the paperwork. Consent forms must be signed by the person legally responsible for the patient. If there are no family members then the Executive Director of the agency must sign and write relationship. **Patient and caregiver may NOT sign consents**. Since health conditions may change over time, we need all paperwork to be completely current.

**Appointment Date**

The tentative date for your appointment is noted below. Once your forms are completed, please send them to our **main office** in Philadelphia. When your forms are received, we will confirm the date for care and finalize treatment details for you. We encourage you to get the paperwork in as soon as possible, because otherwise the client's care will be further delayed.

**Emergency Care?**

If your client requires emergency care, we must still go through the same processes, but our office would be happy to assist in expediting the paperwork through the system. Please note that a dental emergency does not always exhibit pain; because swollen and bleeding gums are also very clear signs of infected gums, constituting a dental emergency.

**Please Be Considerate**

Because of the specialization of this care, and because most patients have this level of care only once a year, we have a lot of professionals involved in each case to ensure it runs smoothly. Although you may not see everyone involved with your client's case, it is unfair to other patients who are waiting for their treatment if your client does not show up prepared for treatment. If you are unable to keep this important time we set aside, please be considerate and notify us immediately.

If you have any questions about the paperwork or the appointment, don't hesitate to call us. If it is after hours, it's OK; just leave a message and someone will get back to you soon. We look forward to seeing you.

Sincerely,

*Joshua A. Bresler D.M.D.*

# RED LION SURGICENTER

240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130


## ADVANCE DIRECTIVE NOTICE

Dear Patient,

Federal regulations require that we inform you in advance of the date of your procedure our policies regarding Advance Directives:

1. Red Lion Surgicenter is a "Full Code" facility. By this we mean that every medical intervention available to us will be used to insure that your procedure has a successful outcome including any and all available resuscitative measures in the case of a medical emergency.

2. We request that all patients who have executed an "Advance Directive" inform us of this fact as soon as possible. Upon notification we will explain our "Full Code" policy in more depth and gain a better understanding of the directives that you have stipulated in the event of a medical emergency.

3. Patients who have executed an "Advance Directive" which include directives that conflict with Red Lion's "Full Code" policy may at anytime decide to cancel their procedure and have it rescheduled at a facility of their choice.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

Special Touch
DENTISTRY
*Providing Special Care in a Special Way*

Dear Patient,

You or your client must be seen by his/her physician for a pre-treatment clearance for care performed under general anesthesia. Attached is the health evaluation form that must be completed by the physician prior to the dental appointment at the Red Lion Surgicenter, the operating rooms utilized by Special Touch Dentistry.

**THE HISTORY AND PHYSICAL MUST BE COMPLETED WITHIN 30 DAYS OF THE SCHEDULED DENTAL APPOINTMENT.**

Please return the original health evaluation form to us. As soon as we receive it, we will contact you to schedule you or your client for care.

Thank you,

*Special Touch Dentistry*

**RED LION SURGICENTER**
240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

# CONDITIONS OF ADMISSION

## Consent to Rendering of Medical Services and Release of Records, Authorization of Financial Responsibility, Benefit Assignment, Receipt of Information and Opportunity to Review Privacy Notice, Disclosure of Ownership

Patient Name: _____

Date of Procedure(s):_____

Scheduled Procedure(s): Oral Rehabilitation (Exam, X-rays, Prophy, Scaling, Fluoride, Sealants, Fillings, Nerve Treatments, Crowns, Extractions, Frenectomy _____ )

I, the above-named patient (or guardian), hereby authorize Dr. _____ (the practitioner) and/or associates or assistants of his choice, to perform the procedure(s) noted above on me/the patient. If any unforeseen condition or situation arises or becomes known to him in the course of carrying out the procedure(s), I authorize the surgeon and/or his associates and/or assistants to provide additional services as they may deem necessary or advisable.

The nature and purpose of the procedure(s), possible alternative treatments, the risks involved and the possibility of complications have been fully explained to me. I have been informed of the risks and benefits of being cared for at the Surgicenter versus a hospital. I acknowledge that no warranty or guarantee has been made as to the result or cure. I understand that the Surgicenter does not provide overnight or 24 hour care.

I consent to the performance of physical examinations and routine diagnostic procedures, and to the injection or other administration of pharmaceutical agents incidental to my/the patient's procedure(s). I understand that physical, protective stabilization (can include but is not limited to holding of hands, feet and head by one of our team members) may be needed to facilitate the rendering of the necessary medical/dental treatment. I understand the reason for this recommendation is for the safety and well-being of my child. I understand this will be provided in the most gentle and compassionate manner possible.

Provided my/the patient's identity is not revealed, I consent to the photographing or recording of my/the patient's procedure(s) for medical or educational purposes. I authorize all providers rendering care, including the practitioners, the anesthetist and any hospital, or their designated representatives, to furnish my/the patient's insurance company with full information regarding treatment rendered (including copies of my records). A copy of this authorization shall be considered as effective and valid as the original. I understand that I am financially responsible to the Surgicenter for any charges incurred by me/the patient and promise to pay the Surgicenter promptly charges that are not paid by an insurance carrier for any reason. If my/the patient's account becomes delinquent, I will pay all reasonable attorney fees, court costs and other expenses pertaining to the collection of such account, whether or not a lawsuit is commenced in connection with such collection efforts.

I understand that any Advance Directive I/the patient may have will not be honored at the Surgicenter and that all necessary resuscitation efforts will be made at the Surgicenter.

I understand that Dr. Bresler has an ownership interest in the Red Lion Surgicenter. I am comfortable with my decision to have the indicated dental procedures performed at Red Lion Surgicenter with the knowledge of this ownership information.

By my signature below, I certify that I have read and fully understand this document, that any explanations requested were made, and that all blanks or statements requiring insertion, striking or completion were filled-in or stricken before I signed.

_____ _____ _____
Patient's Signature Practitioner's Signature Date

If patient is unable to sign or if the financially responsible/insured person is other than patient, complete the following:

☐ Patient is unable to sign because: ☐ Minor ☐ _____

_____ _____ _____
Other responsible party signature Practitioner's signature Date

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

_____
Witness

(revised 5.28.19)

Patient Label

**Philadelphia Department of Public Health (2009)**
**Information Sheet – Amalgam dental fillings containing mercury**

The Philadelphia Department of Public Health has developed this information sheet pursuant to Section 1, Title 9, Chapter 9-3100 of the Philadelphia Code. Its purpose is to give you information about amalgam fillings that contain mercury and other dental filling options. Your dentist's office should provide you with a copy of this sheet and answer any questions that you may have.

**1. What is dental amalgam?**

- Dental amalgam is the silver-colored material used to fill (restore) teeth that have cavities. It is one of several approved choices for filling cavities.
- Amalgam is made up of 50 percent mercury, a type of metal. Amalgam also contains other metals including silver, tin, copper, and zinc.

**2. Is dental amalgam that contains mercury safe?**

- There is ongoing research and discussion about the health effects of mercury in amalgam fillings.
- Small amounts of mercury are released as a vapor (gas) when amalgam fillings are placed or removed and through chewing. This mercury can be absorbed by the body and may build up over time.
- High levels of mercury can cause toxic effects on the brain, nervous system, and kidneys.
- Generally, people with amalgam fillings have higher levels of mercury in their blood and urine than people without amalgam fillings. The mercury levels in people with amalgam fillings are not high enough to be considered toxic.
- So far, well-done studies have shown that amalgam fillings do not impact behavior, information processing, and kidney function among children.
- It is more difficult to study the long-term effects of dental amalgam (effects that may appear later in life). Research in this area is still being performed.
- The Food and Drug Administration (FDA), which regulates the safety of medications and medical devices, has stated that "dental amalgams contain mercury, which may have neurotoxic effects on the nervous systems of developing children and fetuses." The FDA is currently reviewing data and will make a decision about how strongly to regulate the use of amalgam.

**3. Are there alternatives to amalgam?**

- Yes. Amalgam is one of several approved choices for filling cavities.
- The most common dental filling used today is resin composite, which does not contain mercury. Resin is usually tooth-colored.
- Other filling materials are a form of glass cement, porcelain, gold, and other metals.

**4. Aside from safety issues, what are the pros and cons of amalgam and alternatives?**

- Amalgam fillings generally last longer than resin composite fillings, so they don't need to be replaced as often.
- Resin composite fillings are tooth-colored and, therefore, are preferred by some people for cosmetic reasons.
- There may be a cost difference between resin composite and dental amalgam.
- To protect the environment, amalgam must be disposed of as a hazardous waste.

**5. What should you do?**

- Talk to your dentist, ask questions, and make an informed choice about dental fillings if you have a cavity.
- Prevent cavities through regular brushing, flossing, and dental exams.
- For more information on amalgam fillings that contain mercury:

  The U.S. Food and Drug Administration Questions and Answers on Dental Amalgam:
  www.fda.gov/cdrh/consumer/amalgams.html
  Centers for Disease Control Dental Amalgam Use and Benefits Fact Sheet:
  http://www.cdc.gov/oralHealth/publications/factsheets/amalgam.htm
  **or call toll-free:**
  The U.S. Food and Drug Administration at
  1-800-638-2041 (option #2) between 8:00 a.m. and 4:30 p.m

**A copy of this information sheet has been provided to the patient (or patient's representative) and his/her questions, if any, have been answered.**

Patient signature_____ Date_____ Dentist signature_____

A statement from Doc Bresler:

Dental amalgam is considered a safe, affordable and durable material that has been used to restore the teeth of more than 100 million Americans. It contains a mixture of metals such as silver, copper and tin, in addition to mercury, which binds these components into a hard, stable and safe substance. Dental amalgam has been studied and reviewed extensively, and has established a record of safety and effectiveness. Hundreds of articles in scientific publications including the *Journal of the American Medical Association*, the *Journal of the American Dental Association* and *Pediatric Dentistry* have concluded that amalgam restorations are safe for children and adults. Two studies in the Journal of the American Medical Association conclude that children with dental amalgam fillings do not experience adverse effects related to neurobehavioral, neuropsychological (IQ) and kidney function, reinforcing the American Dental Association's longstanding position on the safety of dental amalgam.

# CONSENT TO ANESTHESIA

I acknowledge that my doctor has explained to me that I will have an operation, treatment, or procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments, and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that I would experience much less pain, discomfort, or anxiety during my planned operation or procedure.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my anesthesia, procedure, or treatment. Although rare, severe and unexpected complications with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack, cardiac arrest, or death.* I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified as they may apply to a specific type of anesthesia.

Furthermore, I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extension of this consent that professional judgment indicates to be necessary under the circumstances.

| | | |
|---|---|---|
| ☐ General Anesthesia | Expected Results | Total unconscious state, possible placement of breathing tube into throat or wind pipe |
| | Techniques | Drug injected into the bloodstream, breathed into the lungs, or by other routes |
| | Risks | Mouth, throat, or jaw pain, hoarseness, injury to mouth, nose, throat, gums, lips, or teeth, awareness under anesthesia, injury to blood vessels or nerves, aspiration of stomach contents into lungs, pneumonia, nausea and vomiting, nosebleeds, muscle soreness, injury to the eyes |
| ☐ Monitored Anesthesia Care (local anesthesia with IV sedation) | Expected Results | Reduced anxiety and pain, partial or total amnesia |
| | Techniques | Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state |
| | Risks | An unconscious state, depressed breathing |

I certify that I have, to the best of my ability, told the anesthesiologist obtaining consent of all major illnesses I have had, of all past anesthetics I have received and any complications of these anesthetics known to me, of any drug allergies I have, and of all medications I have recently taken, including aspirin, over-the-counter medications, pain medications, herbal supplements, and recreational street drugs. I have also responded truthfully to any additional questions asked by the anesthesiologist.

If I am pregnant, I understand that elective surgery should be postponed until after the baby is born. Although fetal complications of anesthesia during pregnancy are very rare, the risks to my baby include, but are not limited to, birth defects, premature labor, permanent brain damage and death of my newborn.

I have listened to Dr._____ Anesthesiologist explain the type(s) of anesthesia/ analgesia I may receive, its benefits, and common foreseeable risks and consequences, as well as those of its alternatives, and now accept his or her recommendation.

By signing this consent form, I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives, and expected results of the chosen anesthetic(s), and that I have had ample opportunity to ask questions and consider my decision. I agree to the above provisions, and hereby consent to the administration of the above checked anesthesia services for my operation, treatment, or procedure. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist.

Signature of Patient _____ Time _____ Date _____

Signature of Patient's Guardian or POA _____ Relationship to Patient _____

Witness to Signature of Patient or Guardian/POA _____

PHYSICIAN CERTIFICATION (please check one):

☐ I have personally explained the above information to the patient or the patient's legal guardian/POA/surrogate healthcare decision maker, if the patient is a minor or otherwise deemed incompetent to consent.

☐ The legal guardian/POA/surrogate healthcare decision maker who consented for this patient is not present on date of surgery, but has had ample opportunity to contact Anesthesiologist and ask questions or raise concerns prior to the day of surgery.

Anesthesiologist _____ Time _____ Date _____

**RED LION SURGICENTER**
240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

# PATIENT CARE TRIAGE CHART

Special Touch DENTISTRY

Appt:_____

Patient Name: _____
Last First Middle

Patient D.O.B._____ Insurance Name_____ ID#_____

Home Address: _____
Street City State Zip

Home Phone :(____) _____ Cell Phone: (____) _____

Contact: _____ Contact Phone: (____) _____

Nurse Consultant: _____ Nurse Phone: (____) _____

**Legal Guardian**: _____Relationship: _____ Phone: (____) _____
Cell: (____) _____

**Consent Authorization**: _____Relationship: _____ Phone: (____) _____

**Email:**_____ Cell: (____) _____

Referring Agency: _____ Phone: (____) _____

Executive Director: _____Phone: (____) _____

Name of person to be contacted regarding appointment: _____
Name Phone Cell

Name of person giving info on the phone: _____ Relationship: _____

Call Center Rep Name: _____ Date: _____

CALL CENTER REPRESENTATIVE TO FILL OUT ABOVE LINE

---

DENTAL PERSONNEL TO FILL OUT BELOW LINE

Medical Diagnosis: _____

Behavioral Diagnosis: _____

Current Medications: _____

Severity Level:
____ Very severe (requires GA)
____ moderately severe (may attempt chair-side care)
____ Non-severe (chair-side care)

Oral Rehab Treatment time Estimate:
_____ Short
_____ Medium
_____ Long

Place of setting determination (circle one): Chair OR
Caregiver Confirmation (circle one): Yes No
Comment (e.g. observation of px, interaction w/ px, caregiver comment):_____

Triage performed by: _____ Date: _____
Location of triage: _____

****Please make every attempt to complete the emailed paperwork including medical history or there is a chance your patient may not be able to be seen at their visit.****

**RED LION SURGICENTER**
240 Geiger Road
Philadelphia, PA 19115
Phone: (215) 676-2232 Fax: (215) 676-7130

## O.R. Reservation

**DOS**: _____ **Start Time**: _____ **Duration:** _____ **Surgeon:** _____

**Patient Name**: _____ **SSN:**_____
**Last First Middle**

**DOB**: _____**Age:** _____ **Gender: M** _____ **F**_____ **Race:** _____ **Religion:** _____

**Address**: _____
**Street City State Zip**

**Home Telephone**: (____)_____ **Alternate Phone**: _____

**If Patient is Unable to Grant Consent:**

**Caregiver Name:** _____ **Home Phone:** _____

**Work Phone:** _____ **Cell Phone:** _____

**Planned Procedure**(s): **Anesthesia Type: General MAC Regional Local Other**: _____

_____ **CPT Code:** _____ **Side: R L B ICD Dx Code:** _____

_____ **CPT Code:** _____ **Side: R L B ICD Dx Code:** _____

_____ **CPT Code:** _____ **Side: R L B ICD Dx Code:** _____

_____ **CPT Code:** _____ **Side: R L B ICD Dx Code:** _____

**Primary Insurance:** _____ **Subscriber's Name:** _____

**ID#:** _____ **Group #:** _____ **Subscriber's DOB:** _____ **SS#** _____

**Pre-Cert #:** _____ **If WC-Subscriber's Employer:** _____

**Employer's Address:**
_____

**Employer's Phone #:** _____ **Claim #** _____

**Secondary Insurance:** _____ **Subscriber's Name:** _____

**ID#:** _____ **Group #:** _____ **Subscriber's DOB:** _____ **SS#** _____

**Primary Care Practitioner:** _____ **Phone #:** _____

**Special Equipment/ Other Notes:** _____

_____

PLEASE FAX THIS SHEET TO 215-676-7130 ALONG WITH A COPY OF THE **FRONT AND BACK** OF THE PATIENT'S **MEDICAL** INSURANCE CARD. THANK YOU.

Patient Label

**RED LION SURGICENTER**
240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

# HEALTH HISTORY QUESTIONNAIRE

Dear Patient/Family:
Patients requiring the services of an anesthesiologist will be seen personally prior to surgery. This health history allows us to identify patients who may need specialized instructions. We depend on this questionnaire, along with information provided by the practitioner and the primary care physician, to develop a plan for the patient's care. Please complete all sections of this questionnaire to the best of your ability. Please PRINT clearly.

| Patient Name: | | Primary Physician: |
|---|---|---|
| Home Phone: | Daytime Phone: | Patient<br>Height: Weight: Age: |

| | YES | NO | COMMENTS |
|---|---|---|---|
| • Is the patient being treated for any medical problems? | ☐ | ☐ | _____ |
| • Does the patient have high blood pressure? | ☐ | ☐ | _____ |
| • Has the patient had a heart attack or angina? | ☐ | ☐ | _____ |
| • Does the patient have a heart murmur? | ☐ | ☐ | _____ |
| • Has the patient had heart surgery or cardiac stents? | ☐ | ☐ | _____ |
| • Has the patient had a cold recently? | ☐ | ☐ | _____ |
| • Does the patient have a cough? | ☐ | ☐ | _____ |
| • Does the patient have asthma or emphysema? | ☐ | ☐ | _____ |
| • Does the patient snore or have sleep apnea? | ☐ | ☐ | _____ |
| • Does the patient have diabetes? | ☐ | ☐ | _____ |
| • Does the patient have a seizure disorder? | ☐ | ☐ | _____ |
| • Has the patient had a stroke? | ☐ | ☐ | _____ |
| • Has the patient had hepatitis or jaundice? | ☐ | ☐ | _____ |
| • Has the patient had symptoms of acid reflux? | ☐ | ☐ | _____ |
| • Does the patient take a blood thinner? | ☐ | ☐ | _____ |
| • Does the patient have psychiatric problems? | ☐ | ☐ | _____ |
| • Does the patient display aggressive behaviors? | ☐ | ☐ | _____ |
| • Could the patient be pregnant? | ☐ | ☐ | _____ |
| • Does the patient smoke presently? If so, how much? | ☐ | ☐ | _____ |
| • Does the patient drink alcohol? If so, how much? | ☐ | ☐ | _____ |

List all medications and herbal supplements the patient is presently taking:_____

_____

List all previous surgery and anesthesia-related problems: _____

_____

List all allergies (food, drug, other substances):_____

_____

Do you have anything specific you want to discuss with the anesthesiologist?

_____

_____ _____

Patient/Authorized Person Signature Date Patient Label

# SPECIAL TOUCH DENTISTRY

240 Geiger Road Philadelphia, PA 19115 (215) 508-4200

Special Touch DENTISTRY

THE FOLLOWING INFORMATION IS TO BE FILLED OUT AT THE SHIFT CHANGE ON THE DAY OF APPOINTMENT AND ACCOMPANY THE PATIENT **ON THE DAY OF SURGERY**:

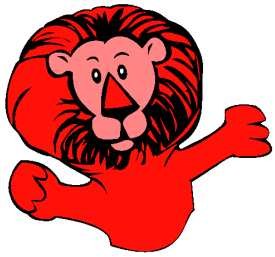
1. Last time patient has had anything to eat or drink _____
2. Allergies ☐ None ☐ _____
3. Medications taken today ☐ None ☐_____
4. Upper respiratory infection in the last month ☐Y ☐N
5. Hospitalization in the last year ☐Y ☐N
   - if yes when and why_____
6. Any new medical problems_____
7. Recent emergency room visits_____
8. Any surgery in the past year_____
9. Does patient take aspirin ☐Y ☐N Was it stopped ☐Y ☐N When_____
10. If patient cannot weight bear, current weight_____
11. Any changes in eating or drinking in the last 3 months ☐Y ☐N
12. Any hitting of the face that is new ☐Y ☐N

Information to be given by nurse or daily caregiver only, not transport personnel.

Signature_____ Title_____

# RED LION SURGICENTER

240 Geiger Road Philadelphia, PA 19115 (215) 676-2232 Fax (215) 676-7130

**PRE-PROCEDURE PREGNANCY TEST WAIVER**

The Surgicenter's policy is to perform a urine pregnancy test on the day of surgery on all women of child-bearing age unless they have had a previous hysterectomy OR they've had both ovaries removed OR they've been menopausal for one year.

As the parent or legal guardian of this patient, at your discretion you may choose to waive the preoperative pregnancy test. If you do, then the Red Lion Surgicenter staff will not perform this test and we would proceed with the dental procedure and general anesthesia without verification of their pregnancy status. Otherwise, it would be performed as per our facility policy.

I acknowledge that surgery/anesthesia may cause congenital abnormalities in fetal development and / or other complications of pregnancy such as, miscarriage, and I understand the implications of having surgery while pregnant.

I also knowledge and understand the pregnancy test may show a false result and are not 100% accurate. I am taking full responsibility that this patient is not pregnant at this time.

Patient's name_____ Date _____

Signature of legal guardian_____ Relationship to patient_____

Printed name of legal guardian_____

**CHOOSE ONE:**

A. This pregnancy waiver applies to only the upcoming dental procedure under general anesthesia at Red Lion Surgicenter. Please ask me about this waiver **each and every time** the patient, for whom I am the legal guardian, comes to Red Lion Surgicenter for such a procedure and general anesthesia._____( signature)

B. This pregnancy waiver applies to **ALL future dental procedures** under general anesthesia at Red Lion Surgicenter. I understand that I may retract this waiver, in writing, at any time. In this case, routine preoperative pregnancy testing, consistent with our facility policy, would be required prior to each procedure._____(signature)

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To Whom It May Concern:

Red Lion Surgicenter and Special Touch Dentistry are committed to providing safe and comprehensive dental care to our patients. We can only provide this outstanding care with your help and participation. Our scheduling department provides a list of each item required by the PA Department of Health and our Anesthesia Department for each patient. In order to schedule a patient when he/she is due, we need this paperwork back at least 4 weeks (30 days) prior to their procedure date. The information you provide is reviewed by our nursing staff and anesthesiologist prior to their procedure which sometimes determines the need for additional information. The 4 week limit enables our staff and yours to get ALL the necessary paperwork in place, and the pre-screening phone call done prior to the patient's procedure to avoid unnecessary day of surgery cancellations.

We are asking for your help in getting this paperwork to us in a timely manner so we can provide the best and safest possible care. If we do not get the paperwork back when our scheduler requests it (**at least 30 days before procedure scheduled**) and if our nurses' pre-screen calls go un-returned, the procedure will be cancelled and put at the end of our list.

We understand the Department of Health has requirements for you to complete annual dental visits and we make every effort to assist you in completing these requirements. However, patient safety is always our first concern and we cannot proceed with cases until our team has reviewed all the appropriate medical information.

Thank you for your attention to this matter.

Sincerely,

Kimberly Rickards, MSN, RN, Director of Nursing

Jessica Coriano, Special Touch Dentistry administrator

# 2BD Anesthesia, PC

Dear Parent,

Re: Anesthesia for Dental Surgery

When your child is scheduled to have dental surgery performed at Red Lion Surgicenter, he or she may require anesthesia for their procedure. 2BD Anesthesia has contracts with almost all of the local health insurance companies. However, payment for anesthesia services for dental procedures is viewed very differently by insurances. It is driven primarily by the specific individual policy as to whether the service is covered or not covered.

If anesthesia is required, we request that you do the following:

1. Please call your insurance company to see if your individual plan covers "anesthesia services for dental surgery at Red Lion Surgicenter".
2. If your carrier does not cover anesthesia services for dental procedures, we recommend you contact your employer's Human Resources department to verify this information.
3. If your insurance does not cover anesthesia services for dental procedures, please see the fee schedule below:

<u>Self-Pay Fees</u>
Per case: $460 for first hour
$120 per each half hour thereafter

If you have any questions, please feel free to call our billing office at 800-242-1131, extension 4192.

November 1, 2019