HISTORY AND PHYSICAL EVALUATION FORM

This form must be completed by your physician *WITHIN 30 DAYS* of your scheduled procedure and *FAXED* to Liberty Surgical Center at 215-673-9236 *10 DAYS PRIOR TO THE PROCEDURE* or surgery may be postponed. (Pennsylvania DOH regulation states this form may not be older than 30 days)

DATE OF SURGERY: ____________ SURGEON'S NAME ____________

Please submit an *EKG with interpretation and physician signature completed within 12 months of scheduled procedure for patients who have cardiac disease (Ischemia, CHF, Arrhythmias, Stroke, ICD/pacemaker) and/or patients 70 years and older.*

Patient Name: ____________ Date of Birth: ____________

Pre-op Diagnosis: ____________ Proposed Surgery: ____________

Allergies / Reaction: ____________

Medications/Dosages: ____________

____

Indications for Surgery:

____

Past MEDICAL History (including pulmonary, cardiac history and psych)

____

____

Past SURGICAL History

____

____

EKG: ☐ Normal
☐ Abnormal, no change from prior EKG COMMENTS: ____________

Physical Examination/Findings

HT: ________ WT: ______ lbs. AGE: _____ yrs. SEX: M / F *Vitals:* BP: ________ HR: ______

General Appearance: ____________

Please check the boxes if there are no significant findings and describe ABNORMAL findings.

☐ HEENT ____________ ☐ LUNGS ____________
☐ HEART ____________ ☐ GI/ABD ____________
☐ GU ____________ ☐ MUSC/SKEL ____________
☐ EXT ____________ ☐ NEURO ____________

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery. It is the surgeon's intention to perform proposed surgery in an ambulatory setting.

Signature ____________ M.D./D.O. Date ____________

Printed Name ____________ Phone# ____________

☐ No Interval Changes since H & P ____________ MD/DO ____________
Surgeon Signature Date

PATIENT LABEL

Liberty SURGICAL CENTER, LLC.

HEALTH SURVEY

Dear Patient: We at Liberty Surgical Center welcome the opportunity to participate in your surgical care. This health survey allows us to better identify those patients who may need specialized instructions. We depend on this survey, along with the information provided by your surgeon and family physician, to provide you with the appropriate care. THANK YOU for taking the time to complete this form. **Please mail the completed survey to Liberty Surgical Center in the envelope provided.**

Name: ______________________________ **Date your surgery is scheduled:** ________
Date of Birth: _________ **Height:** __________ **Weight:** _______**lbs. Surgeon:** ___________
Home Phone: _________________________ **Cell phone:** ________________________

HIPAA GUIDELINES:
May we leave a detailed message on patient's answering machine: YES or NO

Please list ALL MEDICATIONS taken regularly:

____

____

____**Please list ALL ALLERGIES to DRUGS, FOOD, etc. AND your REACTIONS:**

____

____

Do you have any LATEX (balloons, gloves, etc.) allergies? (Please circle) Yes NO
Please list any previous surgeries/dates:______________________________________

____

____

Question	Yes	No	Comments
Do you have high blood pressure?			
Do you have heart trouble or a heart murmur?			
Do you have a pacer defibrillator implant? If so, when was it inserted?			
Have you had a heart attack? If yes, when?			
Do you have angina or chest pain?			
Do you have *SLEEP APNEA?* Has it been diagnosed?			
Have you been to the emergency room or hospital in the last six months?			
Do you have *diabetes?*			
Do you have emphysema or bronchitis?			
Do you have asthma? If yes, last attack?			
Have you had a cold within the last month?			
Do you get short of breath walking up stairs?			

Liberty SURGICAL CENTER, LLC.

HEALTH SURVEY

Do you have a new cough with mucus?			
Question	**Yes**	**No**	**Comments**
Do you have any problems with your thyroid?			
Do you have or have you ever had a seizure disorder?			
Do you have weakness or paralysis of arm/leg?			
Have you had a stroke? If yes, when?			
Do you have chronic kidney disease?			
Do you have a bleeding disorder or bruise easily?			
Do you have heartburn more than 1time weekly? Hiatal hernia?			
Have you ever had hepatitis or jaundice?			
Do you have any psychiatric problems?			
Could you be pregnant? Date of LMP			
Have you or anyone in your family ever had a problem with anesthesia other than nausea/vomiting?			
Have you ever smoked? How much? Have you quit? When?			
Do you drink alcohol? How much?			
Do you take any *over the counter medications, herbal, vitamins or recreational drugs?* If so, what?			
Are you currently undergoing any dental work for an abscess or other infection?			
Do you have any loose, false, capped, bonded or chipped teeth?			
Do you have any hearing or visual problems?			
Do you have radioactive seeds in your body for prostate cancer?			
Do you have a history of using FLOMAX medication?			
Have you ever been treated for a MRSA infection? If yes, When?			

Date: ______________________________ **Signature:** ______________________________

Declaration

I, ______________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.
In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I ( ) do ( ) do not want cardiac resuscitation.
I ( ) do ( ) do not want mechanical respiration.
I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I ( ) do ( ) do not want blood or blood products.
I ( ) do ( ) do not want any form of surgery or invasive diagnostic tests.
I ( ) do ( ) do not want kidney dialysis.
I ( ) do ( ) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other instructions:

I ( ) do ( ) do want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable):

Name and address of substitute surrogate (if surrogate designated above is unable to serve):

I made this declaration on ____________________, 20_______.

Declarant's signature: ______________________ Declarant's address: _________________________

____

The declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

______________________________ ______________________________
Signature of Witness Address of Witness

Advance Directives in Pennsylvania

In Pennsylvania, capacitated adults have the right to decide whether to accept, reject or discontinue medical care and treatment. There may be times, however, when a person cannot make his or her wishes known to a medical provider. For example, a person may be incompetent, in a terminal condition or in a state of permanent unconsciousness, and unable to tell his or her doctor what kind of care or treatment he or she would like to receive or not to receive. This can be addressed through an advance directive.

What is an advance directive?

An advance directive is a written document that you may use, under certain circumstances, to tell others what care you would like to receive or not receive should you become unable to express your wishes at some time in the future. An advance directive may take many forms, and is commonly referred to as a "living will." In Pennsylvania, a living will is known in the law as an advance directive for health care.

What is a living will?

In Pennsylvania, a living will is an advance directive for health care and is a written "declaration" that describes the kind of life-sustaining treatment you want or do not want if you are later unable to tell your doctor.

When does my living will take effect?

The living will, or advance directive for health care declaration, becomes operative when:

- Your doctor has a copy of it.
- Your doctor has concluded that you are incompetent and you are in a terminal condition or in a state of permanent unconsciousness.

Who can make a living will?

Any competent person who is at least 18 years old, or is a high school graduate, or is married can make a living will.

What does it mean to be "incompetent"?

Incompetence is the lack of sufficient capacity for a person to make or communicate decisions concerning himself or herself. The law allows your doctor to decide if you are incompetent, or in a terminal condition or permanently unconscious for purposes of a living will.

How should my living will be written?

There is no single correct way to write a living will or declaration. However, your living will is not valid unless you sign your living will. If you are unable to do so, you must have someone else sign it for you, and two people who are at least 18 years old must sign your living will as witnesses. Neither of those witnesses may be the person who signed your living will on your behalf if you were unable to sign it yourself. It is suggested that you also date your living will, even though the law does not require it. In Pennsylvania, you are not required to have your

living will notarized; however, if you are contemplating using the document in another state, you should find out if the other state requires notarization.

What if my doctor or health care provider refuses to follow the directions in my living will?

Your doctor and any other health care provider must inform you if they cannot in good conscience follow your wishes or if the policies of the health care provider prevent them from honoring your wishes. This is one reason why you should give a copy of your living will to your doctor or to those in charge of your medical care and treatment. The doctor or other health care provider who cannot honor your wishes must then help transfer you to another health care provider willing to carry out your directions — if they are the
kind of directions which Pennsylvania recognizes as valid.

How is an advance directive for health care terminated?

Pennsylvania's living will law states that you may revoke a living will at any time, and in any manner. All that you must do is tell your doctor or other health care provider that you are revoking it. Someone who saw or heard you revoke your declaration may also tell your doctor or other health care provider.

CONTACT: For assistance in obtaining an attorney if you do not have a family attorney, or for further information, contact your local Area Agency on Aging, the Pennsylvania Bar Association, Legal Counsel
for the Elderly at 202-434-2120.

For a copy of the booklet *Understanding Advance Directives; Living Wills and Powers of Attorney in Pennsylvania* write:

PA Department of Aging
Press Office
555 Walnut St., 5th Floor
Harrisburg, PA 17101-1919
717-783-1549

Dear Patient:

Welcome! Thank you for choosing to have your surgery at Liberty Surgical Center.

Please read the following information carefully. This will allow us to provide you with the most efficient and pleasant experience as you prepare for surgery. Please also note that your health and safety is dependent on following these directions.

1. Please return the enclosed Health Survey at least one week prior to surgery.

2. The History and Physical Evaluation Form must be completed by your physician or cardiologist within 30 days of your scheduled procedure.

3. If your doctor gave you orders for lab work, EKG or other tests, these must be completed 14 days prior to surgery. Please be advised that you may have to be rescheduled if we do not receive the test results and the history and physical form sufficiently in advance of your scheduled surgery.

4. If you are currently taking any diet or herbal supplements, please contact your surgeon for further instructions.

5. If you are currently taking anticoagulants, aspirin or products containing aspirin, please contact your surgeon for further instructions. Your surgeon may want you to stop taking these medications for some period both before and after surgery. **DO NOT stop taking any of these medications unless your surgeon advises you to do so.**

6. If any change occurs in your physical condition five days or less prior to your procedure (if you develop a cough, sore throat, infection or fever), please contact your surgeon.

7. **You are not allowed to drive after your surgery. A responsible adult must drive you. The driver or another responsible adult must stay for the duration of the procedure or your procedure will be rescheduled for another day. It is strongly recommended that a responsible adult stay at home with you for the first 24 hours after anesthesia.**

9122 Blue Grass Road
Philadelphia, PA 19114
(215) 673-9231

8. We will call you one week prior to your surgery date to confirm your co-pay and/or deductible, if required. All payments are due the day of surgery.

   We will call you by 3:00 PM the day before your scheduled surgery with instructions and arrival time.

9. DO NOT eat or drink anything (**including gum, mints or candy**) after midnight prior to your surgery unless instructed to do otherwise.

10. Remove all jewelry (including pierced jewelry) and makeup. This includes: foundation, mascara, eyeliner, eye shadow, brow pencil and lipstick. If you wear contact lenses or glasses, please bring a case for their safekeeping. Wear loose fitting, comfortable clothing the day of surgery.

11. Please leave all valuables at home (wallets, purses, etc.) and bring only your insurance cards, photo ID and any co-pay that is applicable.

12. **If you have a Medical Power of Attorney (POA), please bring it with you.**

You will receive written discharge instructions following your surgery. A post-operative phone call will also be made to you to see how you are feeling and to answer any questions or concerns you may have. If we fail to reach you by phone after two attempts, a courtesy letter will be mailed to you.

Our aim at Liberty Surgical Center is to insure you have your scheduled procedure in our safe, comfortable, pleasant facility with the convenience of returning home the same day. In the unlikely event that your condition requires extended care, arrangements will be made for your transfer to a hospital.

Thank you. We look forward to the opportunity to serve you.

Sincerely,

The Staff at Liberty Surgical Center

Liberty
SURGICAL CENTER, LLC.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

RIGHTS:

1) A patient has the right to respectful care given by competent personnel.

2) A patient has the right to, upon request, to be given the name of his/her attending practitioner, the names of all other practitioners directly participating in his/her care and the names of other health care persons having direct contact with the patient.

3) A patient has the right to change practitioner, if other qualified practitioner is available.

4) A patient has the right to consideration of privacy concerning his own medical care program. Care discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.

5) A patient has the right to have records pertaining to his/her medical care treated as confidential except as otherwise provided by law or third party contractual arrangement.

6) The patient has the right to know what Ambulatory Surgical Facility rules and regulations apply to his conduct as a patient.

7) The patient has the right to expect emergency procedures to be implemented without unnecessary delay.

8) The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

9) The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis, including information about alternative treatment and possible complications. When it is not medically advisable to give information to the patient, the information shall be given on his behalf to the responsible person.

10) Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of the procedure. Informed consent is defined in section 103 of the Health Care Services Malpractice Act.

11) A patient, or if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or the responsible person, shall give informed consent to actual participation in the program. A patient, or responsive person, may refuse to continue in a program to which he has previously given informed consent.

12) A patient has the right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.

13) A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, and handicap, disability or source of payment.

14) The patient who does not speak English shall have access, where possible, to an interpreter.

15) The Ambulatory Surgical Facility shall provide the patient, or patient designee, upon request, access to the information contained in his/her medical records, unless access is specifically restricted by the attending practitioner for medical reasons.

16) The patient has the right to expect good management techniques to be implemented within the Ambulatory Surgical Facility. These techniques shall make effective use of time of the patient and avoid the personal discomfort of the patient.

17) When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
18) The patient has the right to examine and receive a detailed explanation of the bill.
19) A patient has the right to expect that the Ambulatory Surgical Facility will provide information for continuing healthcare requirements following discharge and the means for meeting them.
20) A patient has the right to be informed of his/her rights at the time of admission.

Resources:
Centers for Medicare & Medicaid- www.coms.hhs.gov/center/ombudsman.asp
Pennsylvania Department of Health- 1-800-254-5164

RESPONSIBILITIES:
AS A PATIENT, YOU ARE RESPONSIBLE FOR:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician.
- Following the treatment plan recommended by the primary physician involved in your case.
- Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.
- Indicating whether you clearly understand a contemplated course of action and what is expected of you and to ask questions when you need further information.
- Your action if you refuse treatment. Leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about and/or copies of any living will. Power of attorney or other directive that you desire us to know about.

COMPLAINTS OR GRIEVANCES:

- It is always best to make every effort to address patient/visitor complaints internally through discussion, investigation and potential action by/among Center personnel and the patient/visitor. Therefore, any and all patient/visitor complaints should initially be brought to the attention of the Center personnel such as the Medical Director or Clinical Manager. If necessary, patients/visitors wishing to register a complaint regarding the Center may do so by calling or writing:

Pennsylvania Department of Health
Division of Acute and Ambulatory Care
7th Forster Street
Room 532 Health and Welfare Building
Harrisburg, PA 17120
1-800-254-5164

Medicare Beneficiary Ombudsman
1-800-MEDICARE (1-800-633-4227)
TTY users should call 1-877-486-2048
www.medicare.gov/Ombudsman/resources.asp

OWNERSHIP:
I am aware that Drs. I. Chaudhry, Kauffman, Siliquini Jr. and Slochower have a financial and ownership interest in Liberty Surgical Center. I acknowledge that I have selected to have the procedure performed at Liberty Surgical Center after considering both my physicians' financial interest in Liberty Surgical Center and my ability to have the procedure performed at a different facility.

SURGICAL CENTER, LLC. Directions to Liberty Surgical Center (215-673-9231)

<u>From points South (North Phila, Wyoming, Cottman, Lower Northeast etc.)</u>

- Take **Roosevelt Blvd (US-1North) to WELSH ROAD.(PA-532).**
- Turn **RIGHT onto WELSH ROAD (PA-532).**
- Turn **LEFT onto BLUE GRASS ROAD (RITE AID & BANK OF AMERICA)**
- Proceed to Liberty Surgical Center (9122 BLUE GRASS ROAD) ahead on your **LEFT.**

<u>From points North (Trevose,Bucks County, Far Northeast Phila, etc.)</u>

- Take **Roosevelt Blvd (US-1 South) to Grant Avenue.**
- Make a **LEFT onto Grant Avenue.**
- Take Grant Avenue to the **2nd light *BLUE GRASS ROAD** at **(WAWA & JOMAR)** then make a **RIGHT.**
- Proceed on **Blue Grass Rd past the Warehouse's and over the railroad tracks**, Liberty Surgical Center (9122 Blue Grass Rd) is on your **RIGHT.**

(* There are two Blue Grass Roads make sure to turn RIGHT on the second Blue Grass Rd.)