Welcome

Desert Orthopaedic Center Surgery Center (DOCSC) wants to thank you for using our facility for your outpatient surgical procedure. DOCSC is licensed by the state of Nevada as an Ambulatory Surgery Center. We have state of the art equipment and a dedicated, experienced staff to care for you. Please read the information below and visit our website for complete instructions at www.doclv.com to assist you in preparing for your upcoming procedure.

Instructions

A nurse will call you the day before your procedure to give you pre-operative instructions and a list of necessary items to bring with you on the day of your procedure.

Children's Procedure

You may bring a favorite toy or blanket the day of your procedure. You must remain in the building the entire time your child is here.

Before Procedure

Make sure you don't EAT or DRINK anything after midnight, not even water (your procedure may be cancelled).

Don't chew gum or eat hard candy after midnight. It is recommended that you refrain from smoking.

Shower and wash your hair before your procedure to decrease the risk of infection.

If you think you may be pregnant, please notify your doctor and anesthesiologist; medications and anesthesia may affect the developing fetus.

You will need an adult at least 18 years old to drive you home after your procedure; please make arrangements in advance. It is helpful if a family member or significant other can be with you for 24 hours following procedure, especially if you have small children at home.

Do not take any medications after midnight unless instructed to do so by your physician or the nurse giving preoperative instructions.

Contact your doctor or the Surgery Center if you are ill and need to cancel your procedure.

Day of Procedure

Please complete all pre-operative paperwork you received from your doctor's office.

Leave jewelry and valuables at home.

Please bring health insurance cards, cash and/or credit card payment, and your driver's license with you on the day of your procedure.

Please bring a list of your medications to the surgery center, dosage and the last time taken with you on the day of your procedure.

Wear loose, comfortable clothing.

You will need someone 18 years or older to drive you home after your procedure.

After Procedure

You will be given instructions regarding your care at home before you leave the facility.

You may have prescriptions from your physician that will need to be filled. It is normal to feel drowsy after anesthesia.

We recommend for the first 24 hours following your procedure that you do not operate equipment or drive, sign important papers, or drink any alcoholic beverages.

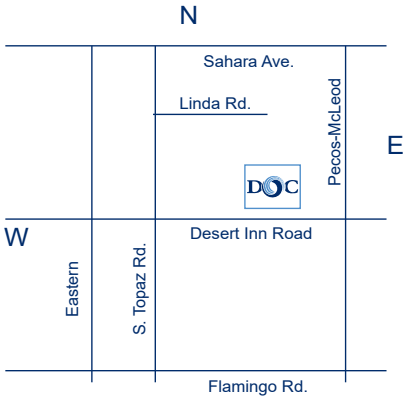
Children should not play on toys that move or roll.

Your procedure is scheduled for:

Day: _____

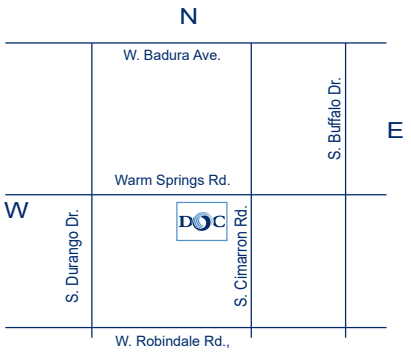
Date: _____

Arrival Time_____ a.m. / p.m.



DESERT ORTHOPAEDIC CENTER
Surgery Center

2800 E. Desert Inn Road, Suite 150
Las Vegas, Nevada 89121
(702) 735-7355 Fax: (702) 735-7921
www.doclv.com



DESERT ORTHOPAEDIC CENTER
Pain Center

8205 West Warm Springs, Suite 130
Las Vegas, Nevada 89113
(702) 731-1616 www.doclv.com

Accredited by
Accreditation Association
for Ambulatory Health Care Inc.

DESERT ORTHOPAEDIC CENTER
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What you need to know before your procedure

WHAT YOU NEED TO KNOW BEFORE PROCEDURE FORM 1 (06.19) ABBOTT'S PRINTING 702-456-8099

[Affix Patient Label]

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Desert Orthopaedic Center Surgery Center (DOCSC) is committed to providing the highest level of patient care. To achieve this objective, we ask our patients or their caretaker to complete a brief patient satisfaction survey after their surgery.

To better serve you, we have automated this process. Within 48 hours of your discharge from our facility, you will receive an email providing you with a link to complete our survey. The survey is performed online via a secure internet connection to the independent company we have hired to gather survey results. Simply follow the instructions and give us your feedback. Patients who complete the survey online will be entered into a monthly drawing for a $100 gift certificate to Amazon.com.

Please write legibly and provide the email address to forward the survey to in the lines below:

_____

If you do not have access to email or a computer, please let us know and we will provide you with a paper version of the survey to compete and return to us.

Si usted quisiera la encuesta en español, por favor, háganoslo saber y nosotros le proporcionaremos una versión impresa de la encuesta para completar y regresarlo a nosotros.

We are committed to protecting the confidentiality of our patient's information and identities and under no circumstances will your information be disclosed or used for marketing purposes.

PATIENT SURVEY (06/19) ABBOTT'S PRINTING 702-456-8099

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IMPORTANT – PLEASE READ

Billing and Charges

Institute of Orthopaedic Surgery, doing business as Desert Orthopaedic Center Surgery Center (DOCSC), is a separate legal entity from your doctor's office. Therefore, you may receive a separate bill from each.

All Surgery Center statements and insurance explanation of benefits you receive will reference Institute of Orthopaedic Surgery.

Ride Home

All patients must have a ride home with someone 18 years old or older. If you do not have a ride, please let your doctor know so we can help arrange a ride for you with an approved service.

If you are arranging a ride home through your insurance company, please ensure they are setting you up with a medical transportation because you will be receiving sedation. A ride-share service (such as Uber, Lyft, etc.) is not an appropriate option for this procedure, unless a friend or family member is accompanying you.

Failure to comply may result in your procedure being canceled.

Please notify your doctor prior to your procedure date if you take any of these drugs:

Plavix (Clopidogrel)

Coumadin (Warfarin)

Lovenox, Xarelto, Celebrex, Pradaxa, Eliquis

For your safety, your procedure may be canceled if you have not informed the doctor performing your procedure.

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PRE-OPERATIVE INSTRUCTIONS FOR PAIN PATIENTS

1. Your pain procedure physician will advise you on **eating and drinking prior to your procedure.** Generally, it is recommended not to eat 8 hours prior and to stop liquids 8 hours before your procedure. This is recommended to prevent aspiration after receiving IV medications.
2. Please be sure to take **your medications** as ordered by your physician. If you are diabetic, be especially mindful of discussing your diabetic medications with your doctor.
3. **Please be on time**. It will take approximately one hour to prepare you for your procedure.
4. **Minor Patients** (under 18 years old)
    a. A legal parent or guardian must remain in the surgery center the ENTIRE time the minor patient is here.
    b. If someone other than the legal parent or guardian is with the child, the legal parent or guardian must provide written permission, along with a copy of their photo ID and a telephone number where they can be reached the day of the procedure.
5. A copy of a **Power of Attorney** may be required if someone is signing for the patient.
6. Please **arrange for someone to stay** with you at least 24 hours after surgery.
7. **Bathe or shower** and wash your hair prior to coming to the surgery center to avoid risk of infection.
8. Do not wear perfume, cologne, body lotion, hairspray.
    a. Wear **loose, comfortable clothing.** Easy-on shoes – no flip flops/thongs
9. Please **remove all jewelry, rings, piercings**, etc.
10. Leave all valuables at home or with your ride.
11. Do **bring a picture ID, insurance card and any copayment** you may have.
12. If you have an Advance Healthcare Directive, bring it with you.
13. **Your ride must remain at the surgery center during your procedure.**
14. **You must have someone 18 years old or older to drive you home**. If you do not have a ride, your procedure may be cancelled. You may not take a taxi, bus, Uber, Lyft, etc. unless you have someone you know over 18 years old with you.

PATIENT HOME MEDICATIONS – Medication Reconciliation

Print Your Name: _____

ALLERGIES & REACTION TO EACH: _____

_____

_____

_____

_____

Please list ALL prescription & over-the-counter (OTC) medications and herbs and vitamins you take.

Prescription & OTC Drugs, Herbs & Vitamin Name(s)	Dose	How many times a day or week do you take this drug?	Date & Time Last Taken

Patient Home Medication Record Completed to the best of the patient's ability and reviewed by Pre-OP RN Initials: _____

NEW MEDICATIONS PRESCRIBED AT DESERT ORTHOPAEDIC CENTER SURGERY CENTER (DOCSC) (to be completed by RN)

DRUG NAME	DOSE	ROUTE	FREQUENCY	LAST TAKEN

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RN Initials _____ ☐ Copy to patient at discharge

PATIENT IDENTIFICATION

PRE-ANESTHESIA QUESTIONNAIRE

Please completely answer ALL the following questions. Thank you!

Name: _____

Date of Birth _____ Sex at Birth: _____ Preferred Pronoums: _____

Height _____ Weight _____ Are you pregnant? YES/NO

Home/Cell Phone #:_____ E-mail Address: _____

Adult driving you home after your procedure? _____ Their Cell #: _____

Do you smoke? YES/NO How much each day? _____ Are you Diabetic? YES/NO

Have you or any family member ever had an unusual reaction to anesthesia? YES/NO Describe: _____

_____ Are you allergic to LATEX? YES/NO

All Allergies / Allergic Reactions: _____

_____

_____

Have you been ill or had a fever lately? YES/NO

Do you have any prosthetics? YES/NO

Are you taking addictive drugs? YES/NO

Do you drink alcohol daily? YES/NO

Do you have, or have ever had, any of the following?

	Yes	No	When?		Yes	No	When?
Lung Trouble	☐	☐	_____	Anemia	☐	☐	_____
Bronchitis / Chronic Cough	☐	☐	_____	Bleeding Problem	☐	☐	_____
Asthma	☐	☐	_____	Hepatitis	☐	☐	_____
Shortness of Breath	☐	☐	_____	Jaundice	☐	☐	_____
Pneumonia	☐	☐	_____	Liver Problem	☐	☐	_____
Emphysema	☐	☐	_____	Gall Bladder Problem	☐	☐	_____
Tuberculosis (TB)	☐	☐	_____	GI Bleeding	☐	☐	_____
Sleep Apnea CPAP?	☐	☐	_____	Seizures / Seizure Disorder	☐	☐	_____
Heart Disease	☐	☐	_____	Stroke	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Paralysis	☐	☐	_____
Heart Attack	☐	☐	_____	Head, Neck or Spine Injury	☐	☐	_____
Heart Murmurs	☐	☐	_____	Kidney Trouble	☐	☐	_____
Chest Pain	☐	☐	_____	Thyroid Disease	☐	☐	_____
Heart Valve Problem	☐	☐	_____	Gastric Reflux (GERD)	☐	☐	_____
Palpitations / Irregular or Fast Beats	☐	☐	_____	Frequent Indigestion	☐	☐	_____
Pacemaker? Rate _____				Hiatal Hernia	☐	☐	_____
High Blood Pressure	☐	☐	_____	Back / Disc Problems	☐	☐	_____
Phlebitis	☐	☐	_____	Sciatica	☐	☐	_____

Any illness or disease not listed? _____

Please provide any information you feel would be helpful to us in caring for you: _____

Previous Surgeries (Check only those surgeries you've had):

☐ Appendectomy ☐ Hernia ☐ Gallbladder ☐ Breast / Biopsy ☐ Glaucoma

☐ Hysterectomy ☐ Cataracts ☐ Sinus / Nasal ☐ Tubal Ligation ☐ Tonsils / Adenoids

☐ Orthopaedic ☐ Other _____

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