Pulse Cardiovascular

CONSENT FOR SURGERY / PROCEDURE(S)

1. I authorize the performance of the following operation / surgical procedure(s) to be performed:

_____

_____

_____by or under the direction : _____

2. My physician(s) has fully explained to me the condition requiring treatment and the nature, purpose, risk and benefits of the operation(s) / procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications. I was given the opportunity to ask questions and any such questions were answered to my satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science.

3. My consent is given with the understanding that any operation or procedure, including anesthesia, involves risks and hazards. The more common risks include; but are not limited to: infection, bleeding requiring blood transfusion(s), nerve injury, blood clots, heart attack, stroke, allergic reaction(s), damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.

4. Surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY, OR DEATH, from both known and unknown causes. Therefore, except in cases of emergency or exceptional circumstances, these operations and procedures will not be performed unless I have had an opportunity to discuss them with my physician. I have the right to consent to or refuse a proposed operation or special procedure.

5. I consent to the performance of operations or other procedures in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, including the implantation of medical devices, which the above named physician(s) or his/her associate(s) or assistant(s) may consider necessary or advisable in the course of the operation.

6. I understand the risks, benefits, and alternatives to the type and method of anesthesia or sedation recommended, and I consent to the administration of such anesthesia as may be considered necessary or advisable by the physician(s) for this surgery / procedure.

7. I understand this surgery center is owned by physician/surgeon investors who also perform procedures at the surgery center, and that I may ask my physician/surgeon or the center administrator for further details. I have been given the option to have this procedure performed at any facility of my own choosing and have designated this facility for my procedure.

8. I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my surgeon(s). I authorize that a physician in training may participate in my care; a representative or technician from a medical device company may be present at the procedure; medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

9. I consent to the disposal of any human tissue or body part which may be removed during the surgery / procedure(s).

10. If complications arise, I agree to be admitted to the hospital of my surgeon's choice, which may incur additional fees not covered by my insurance.

11. I have been advised that there is a possibility of damage to teeth during surgery and administration of anesthesia, particularly if the teeth are weak, loose, decayed or artificial, and I waive any claim for damage to teeth as a result thereof.

12. I understand that, unless instructed otherwise, I am required to have a responsible adult accompany me after my surgery / procedure(s) and that I will be released to that person's custody and must rely upon him/her for my return home and supervision, as instructed.

13. I release the surgery center from any responsibility for loss of and/or damage to money, jewelry, or other valuables I have brought to the surgery center.

14. I understand that if I am pregnant, or if there is the possibility that I may be pregnant, I must inform the surgery center immediately since the scheduled surgery / procedure(s) could cause harm to my (unborn) child or myself.

15. If I am not the patient, I represent that I have the authority of the patient whom, because of age or other legal disability, is unable to consent to the matters above. I represent that (a) I have the full right to consent to the matters above; (b) I agree to release, indemnify, and hold harmless the surgery center, its employees, agents, medical staff, partners, and affiliates from any liability or cost arising out of my lack of adequate authority to provide the consent set forth herein.

16. In the event of any health care provider, who during my treatment, sustains a puncture, mucous membrane or open wound exposure to blood or other bodily fluids, I permit the surgery center to perform a blood test for HIV (the AIDS virus). A test for Hepatitis B and C may also be drawn.

17. I have not had anything to eat or drink since _____.

18. Advance Directives – Living Will – Health Care Proxy I understand that Advance Directives and Living Wills are NOT honored at the surgery center, and in the event of an emergency or life threatening situation, advanced cardiac life support will be initiated in every instance and patients will be transported to a facility providing a higher level of care.

19. I have reviewed and understand the Patient Bill of Rights provided to me by Pulse Cardiovascular staff.

[ ] I have provided the surgery center with my Advance Directive/Living Will/Health Care Proxy.

[ ] I have Advance Directive/Living Will/Health Care Proxy, but I have not provided them to the facility. I have been offered executable copies and have refused.

[ ] I do not have an Advance Directive/Living Will/Health Care Proxy.

[ ] I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

[ ] I decline information on how I can obtain Advance Directive/Living Will/Health Health Care Proxy

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT THAT: 1. I have read, understand and agree to the foregoing; 2. The proposed surgery / procedure(s) have been satisfactorily explained to me and that I have all of the information that I desire; 3. I hereby give my authorization and consent, and; 4. All blank spaces on this document have either been completed or crossed off if they do not apply prior to my signing.

_____ _____ _____

Patient's Signature **Date** **Time AM PM**

_____ _____ _____

Witness Signature **Date** **Time AM PM**

I have read and understand the above and give my consent, as the parent, guardian, and/or relative of the patient, to have the procedure(s) performed.

_____ _____ _____

Patient's Agent Signature **Relationship to Patient** **Date/Time AM PM**

_____ _____

Witness Signature **Date/Time AM PM**

TRANSLATOR'S STATEMENT: I have verbally translated this consent into (applicable language) _____for the benefit of the patient or his/her authorized representative who understands said language better than English. To the best of my ability, I believe the patient or his/her representative understands these statements, as witnessed by their signature on the consent form. Translator's initials:_____

_____ _____

Provider Signature **Date**

Pulse Cardiovascular

Patient Release, Authorization, and Assignment of Insurance Benefits

Healthcare billing is complicated, with every insurance company providing a plethora of different plans each with varying levels of coverage. As a result, we may not be contracted with your specific carrier or our services or any part thereof may not be covered by your plan. We would like to limit that stress for you and will, with your permission, interact with your insurance company to smoothen the process. Your signature below is your consent to allow us to release the required information to your insurance company during the processing of the claim for services, as patient information is confidential by law.

I, _____, hereby authorize Pulse Cardiovascular Institute LLC, Ambulatory Cardiovascular Management LLC and their agents or associates to acquire from and/or release to my healthcare professionals and/or insurance companies any information required for the purposes of all medical billing and/or the processing of all medical claims related to the surgery for which Pulse Cardiovascular Institute LLC and its physicians/agents have provided services. I understand by agreeing to this surgery or procedure, I am assuming responsibility for any deductible, co-pay, co-insurance, or other amounts not covered by my insurance carrier. I specifically authorize Pulse Cardiovascular Institute LLC to submit claims to my insurance company on my behalf and to direct my insurance company to pay the appropriate benefits directly to Pulse Cardiovascular Institute LLC.

I understand if payment is denied by my insurance company, I will be responsible for the services. I understand that should any payment for these services be paid to me directly, those monies rightfully belong to Pulse Cardiovascular Institute LLC and I will remit that check(s) to Pulse Cardiovascular Institute LLC forthwith. I understand that Pulse Cardiovascular Institute LLC may exercise its rights under the law in the event my account for these medical services is not paid and that I will be responsible for the attorneys' fees and costs should that be necessary.

_____

Patient Signature Date

_____

Primary Policy Holder Date

Pulse Cardiovascular

Consent For Anesthesia Services

I, _____ , have been scheduled for_____
_____
_____
surgery. I understand that anesthesia services are needed so that my doctor can perform the 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 procedure or treatment. **ALTHOUGH RARE, SEVERE UNEXPECTED COMPLICATIONS CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF VISION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.** I understand that these risks apply to **ALL** forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Result	"Not awake" – an unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks (include but not limited to)	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia.
☐ Monitored Anesthesia Care	Expected Result	"Could be awake" - Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes, producing a semi-conscious state.
	Risks (include but not limited to)	Memory of procedure/awareness - anxiety and/or discomfort, an unconscious state, depressed breathing, injury to blood vessels

I consent to the anesthesia service checked above and authorize that it be administered by Arizona Anesthesia Solutions through a board-certified anesthesia provider, either a Certified Registered Nurse Anesthetist, or an Anesthesiologist. I also consent to any alternative types of anesthesia, if necessary, as deemed appropriate by my anesthesia provider for my safety and comfort.

I understand the importance of providing my health care providers with a complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol or any type of illegal drug may give rise to serious complications and must also be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decisions.

_____
Patient's Signature *Date and Time*

_____
Anesthesia Provider's Signature

_____
Substitute's Signature *Relationship to Patient*

Pulse Cardiovascular

Patient Name:

Patient DOB:

MRN:

Labs & Testing

EKG: _____ Date Performed: _____

PT/INR: _____ Date Performed: _____

Glucose: _____ Date Performed: _____

HCG Pregnancy Test: _____ Date Performed: _____

Creatinine: _____ Date Performed: _____

➔ Calculated GFR: _____

Other (specify): _____ Date Performed: _____

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MEDICATION RECONCILIATION LIST

Completed by:_____ Date:_____

Name of Pharmacy:_____ Medication Allergies:_____

Current Medications

Medication Name	Dose	How Often	Discontinued	Last Taken

Added Medications

Medication Name	Dose	How Often	Start Date

Medication List Reviewed

Medication list reviewed with patient	**YES** **NO**	Date/Time:	By:

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PRE-OPERATIVE EXAM NOTE

DATE & TIME:	**SURGEON NAME:**
PRE-OP DIAGNOSIS:	
PATIENT EXAMINATION & PROCEDURE PLAN:	

☐ I have reviewed the patient's history and physical and have assessed all risks of and alternatives to surgery.

_____

PHYSICIAN SIGNATURE

Pulse Cardiovascular

IMMEDIATE POST-OP PROGRESS NOTE

DATE & TIME:	**SURGEON NAME:**
PRE-OP DIAGNOSIS:	
POST-OP DIAGNOSIS:	
EBL:	
ANESTHESIA USED:	
FINDINGS/PROCEDURE NOTES:	
COMPLICATIONS:	

_____

PHYSICIAN SIGNATURE

Pulse Cardiovascular

ANESTHESIA RECORD

ANTIBIOTIC_____

TIME OF 1ST DOSE _____2ND DOSE_____

PT Name: _____

PT DOB: _____

MRN: _____

OPERATION_____

SURGEON(S):_____ ANESTHESIOLOGIST: _____ DATE: _____

AGENTS & DURGS

ECG

O2 SAT %

FiO2

ET CO2

TEMP

PRE-ANESTH CHECK: 200

Suction ☐

O2 Supply ☐

Circuit ☐

150

PT PRE-INDUCTION:

VITAL SIGN CHECK ☐

100

ALARMS

Pressure ☐

FiO2 ☐

LEGEND

v	SBP	50
^	DBP	
.	Pulse	
T	Art BP	
		0

VENTILATION

EYE CARE

	Left	Right
Lube	☐	☐
Tape	☐	☐

Notes:

POSITION

TIME: ATTEND PT: BEGIN ANES: BEGIN SURGERY: END SURGERY: LEAVE RM: LEAVE PT:

IV	GAUGE	TYPE	SITE	AIRWAY	SIZE	Notes:
1				OP/NP		Trach:
2				OT/NT		Breath Sounds Equal YES NO
3				LMA		Equal Chest Expansion ☐
4				ENDOTRACH INSRT	cm	$ETCO_2$ ☐

CLASS II – IV CONTROLLED DRUG DOCUMENTATION

	DRUG	OBTAINED BY	AMOUNT OBTAINED	USED	RETURNED	WASTED		WITNESSED BY
	1.							
	2.							

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PRE-OP ANESTHESIA ASSESSMENT

PT Name: _____

PT DOB: _____

MRN: _____

PREANESTHETIC INFORMATION

DATE:		WT:		HT:		LAB DATA:						NPO:		☐

Drug Allergies & Reactions

Drugs and Dosages:

Family History of anesthetic problems:

Past anesthesia experiences and surgical history:

DISEASE HISTORY	CV:		CAD MI Angina CHF Arrhythmias Murmur Hypertension Ablation EF Stress Test
	PULM:		Asthma COPD URI Sleep Apnea CPAP Smoker Emphysema TB
	RENAL:		Dialysis Renal Insufficiency Renal Failure
	NEURO:		TIA CVA Seizures Nerve Deficit
	GI/HEPATIC:		Jaundice Hepatitis Infections Hiatus Hernia Peptic Ulcer HIV MRSA VRE
	GENERAL:		Anemia Diabetes Arthritis Dental Problem Obesity ETOH Drug Abuse Pregnancy

RELEVANT PHYSICAL EXAM:	Mental Status:	Heart:	Lungs:		Airway:

COMMENTS: _____

☐ Anesthetic plan, risks, benefits, and alternative discussed with patient and/or family ☐ Patient appears to understand ☐ Family/Guardian present

Anesthesia Plan: ☐ General ☐ Regional ☐ MAC

ASA Physical Status: 1 2 3 4 5 E

SIGNATURE _____ DATE _____ TIME _____

ANESTHESIA SUMMARY

Anesthesia: ☐ General ☐ MAC

Special Techniques: Warming Device Other

Course of Anesthesia:

Est. Blood Loss: Urine Output:

Fluid Summary:	Blood Products and Reason:

POST-ANESTHESIA NOTE

HR _____ **BP** _____ **RR** _____ **O2 SAT** _____ **TEMP** _____

MENTAL STATUS: ☐ AWAKE ☐ AROUSABLE ☐ UNRESPONSIVE

NOTES: _____

SIGNATURE _____ DATE: _____ TIME: _____

Pulse Cardiovascular

Post-Operative Orders

Patient Name_____

DOB_____

Patient number_____

NURSING

- Vitals per Policy
- O2 Via Mask or NC to Keep O2 >92%
- Bedrest Until
- Warming to keep Temp >36 C
- Diabetic Post Op Blood Glucose Check

MEDICATIONS

- Zofran 4mg IV for Nausea
- Fentanyl____mcg IV for Pain X1
- Toradol_____ mg IV/IM for Pain
- Ativan ___mg x1
- Diphenhydramine 25mg IV x1 for Pruritus May repeat x1

DISCHARGE

- The patient may be discharged from the PACU to home once they are awake and alert and easily arousable, hemodynamically stable, can maintain O2 Sats >92% on Room air, have no active bleeding or post-operative complications

OTHER ORDERS

_____
_____
_____
_____
_____
_____

MD SIGNATURE_____

Date _____

PULSE CARDIOVASCULAR INSTITUTE

GENERAL DISCHARGE INSTRUCTIONS

For at least 24 HOURS following your procedure:

- Have a responsible adult available to you.
- Leave surgical dressing in place.
    - After 24 hours, you may remove the dressing and take a shower, but NOT a bath (see below).

For at least TWO DAYS following your procedure:

- Do not drink alcohol, drive, or operate heavy machinery.
- Avoid making any major decisions or signing important documents.

For at least ONE WEEK following your procedure:

- Avoid all baths, pools, hot tubs, and any other activities that involve submerging the surgery site.

For at least TWO WEEKS following your procedure:

- No heavy lifting or strenuous pushing/pulling motions (e.g. mowing the lawn, mopping).

Additional instructions:

- Avoid using Tylenol if you are taking Vicodin, Percocet, or other medications containing Tylenol.
- Take all other medication as directed. Remember to avoid driving or operating heavy machinery whenever taking narcotic pain medication.
- Take a short walk around the house every hour or so while awake. This helps to prevent blood clots.
- Drink plenty of water to stay hydrated.

Call the office immediately at 480-912-4747 if you experience any of the following symptoms:

- Increased pain, redness or drainage from surgery site
- Temperature over 101 °F
- Nausea, vomiting, chest pain, or shortness of breath within 48 hours of surgery

In case of emergency, call 911 or go directly to the emergency room.

Notes: _____

_____

_____

Follow-up appointment: _____ / _____ / _____ @ _____ : _____

Responsible Party Signature: _____ **Date:** _____

MD or RN Signature: _____ **Date:** _____

✉ 7285 E. EARLL DRIVE, BLDG C, SCOTTSDALE, AZ 85251 ☎ 480-912-4747