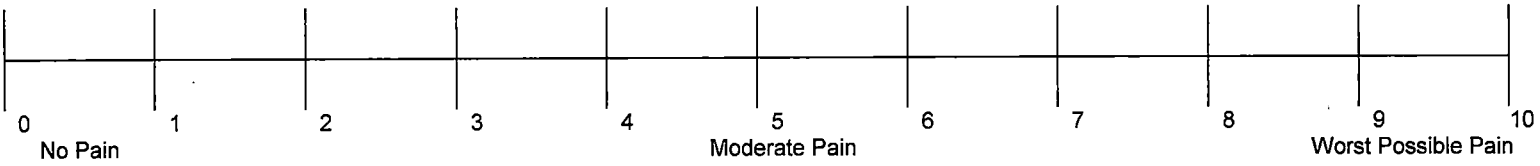
ORLIN & COHEN ORTHOPEDICS

☐ 1728 SUNRISE HWY., MERRICK, NY 11566
☐ 1101 STEWART AVE., GARDEN CITY, NY 11530
☐ 45 CROSSWAYS PARK DRIVE WOODBURY, NY 11797

PATIENT INFORMATION

May we contact you at home following the procedure? ☐ Yes ☐ No Ph#_____
May we contact you at work following the procedure? ☐ Yes ☐ No Ph#_____
May we leave a MESSAGE at home? ☐ Yes ☐ No
May we leave a MESSAGE at work/cell? ☐ Yes ☐ No
Who may we speak with at home? _____
Who may we speak with at work? _____

Please provide us with an evaluation of the pain you are experiencing using the scale below and provide a description of your pain (for instance, dull, aching). _____



Patient Signature

POST-OPERATIVE CONTACT

Note: If the first two attempts are unsuccessful try another number or a different time.

Telephone call made to: ☐ Home ☐ Office ☐ w/Family/Friend ☐ Other:_____

1 Date: _____ Time: _____ Phone Call made by: _____ ☐ No answer ☐ Contact

2 Date: _____ Time: _____ Phone Call made by: _____ ☐ No answer ☐ Contact

3 Date: _____ Time: _____ Phone Call made by: _____ ☐ No answer ☐ Contact

1	Patient have any numbness?	☐ Yes ☐ No	6	Redness at injection site?	☐ Yes ☐ No
2	Patient experiencing weakness?	☐ Yes ☐ No	7	Any increase overall pain level?	☐ Yes ☐ No
3	Drainage from injection site?	☐ Yes ☐ No	8	Nausea/Loss of Appetite?	☐ Yes ☐ No
4	Any unusual or excessive pain?	☐ Yes ☐ No	9	Fever?	☐ Yes ☐ No
5	Swelling, pain at injection site?	☐ Yes ☐ No	10	Chest pain, shortness of breath?	☐ Yes ☐ No
	Patient prescribed pain medication?	☐ Yes ☐ No		Patient eaten since procedure?	☐ Yes ☐ No
	Patient taking pain medication?	☐ Yes ☐ No		Follow-up appointment?	☐ Yes ☐ No

#1-10 – if Yes, Provide Information Below

GENERAL COMMENTS BY PATIENT:

GENERAL COMMENTS BY CALLER:

Signature MD/RN/PA Print Name Date

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PERI-OPERATIVE NURSING RECORD

When did you last eat or drink? _____ AM/PM Age_____ Weight _____ Height_____

Do you have any allergies to medications? ☐ **No** ☐ **Yes** **If Yes,** _____
Please list above.

Are you allergic to latex, eggs, Iodine, shellfish or sulfites? ☐**No** ☐ **Yes** **If so, list below:**
_____/_____/_____/_____/_____

DO YOU USE: **Glasses?** No Yes **Contact Lenses?** No Yes **Hearing Aid?** No Yes **Dentures?** No Yes

Are any of your teeth loose, weak, or broken? No Yes
Do you smoke cigarettes now? No Yes
Do you take any drugs for non-medical use? No Yes
Do you drink alcoholic beverages daily or frequently? No Yes

Have you taken Plavix within the last 14 days? No Yes
Have you taken Antibiotics within the last 14 day? No Yes **If yes, what type?**_____
Have you taken Coumadin, Aspirin, Ibuprophen or any anti-inflammatory in the last 7 days? ☐ **No** ☐ **Yes If so, please list:**
_____/_____/_____/_____/_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

High blood pressure.....	No	Yes	Kidney disease/prostate disease.....	No	Yes
Heart attack.....	No	Yes	Diabetes.....	No	Yes Glucose result _____
Valvular heart disease.....	No	Yes	Thyroid disease.....	No	Yes
Chest pain, angina.....	No	Yes	Convulsions or epilepsy.....	No	Yes
Permanent pacemaker/AICD.....	No	Yes	Stroke, paralysis, arm/leg weakness.....	No	Yes
Cardiac stent.....	No	Yes	Depression or anxiety.....	No	Yes
Asthma/emphysema.....	No	Yes	Arthritis.....	No	Yes
A cold at present/frequent cough or sputum.	No	Yes	Bleeding/disorder or bruising easily.....	No	Yes Protime result _____
Sleep apnea.....	No	Yes	Liver disease, jaundice, hepatitis.....	No	Yes
			High cholesterol/lipid.....	No	Yes
Hiatal hernia gastroesophageal reflux.....	No	Yes	Any other serious illness.....	No	Yes What?_____
Cancer.....	No	Yes	Communicable Disease.....	No	Yes What? _____
If so, where?.....	No	Yes	Are you pregnant	No	Yes UCG result _____
Have you or anyone in your family had			Last menstrual date: _____		
complications from anesthesia?.....	No	Yes	**Primary M.D.** _____		
			Name		Phone

Past Surgical Procedures with Anesthesia: _____

( ) I was instructed not to eat, drink, or take any medication (unless specified by my physician) after midnight last night and that I have followed those instructions.
( ) I have made arrangements to have a responsible adult drive me home. I understand that I will not be released unescorted, or only accompanied by a minor. I do not plan to drive a car or even take a cab alone.
( ) I agree that Orlin & Cohen is not responsible for any valuables that I have elected to bring.

_____ _____
Signature of Patient **Date**

Name/ID Verified: Y N **ID Band Y/N** **Admission Time:** _____

Pre-Operative Vital Signs: BP _____ HR _____ RR _____ 02Sat_____Temp _____IV Inserted ☐ Right ☐ Left _____

_____ _____
R.N. Signature **Date**

_____ _____
Reviewed by Anesthesiologist/CRNA **Date**

☐ Plan of care discussed between Anesthesiologist and CRNA. _____
Initial