



ENT Surgery Center of Augusta
706-868-5676





PARENTS/GUARDIANS

PLEASE READ BEFORE THE DAY OF PROCEDURE

Eating or drinking rules before your child's surgery

Food and drink taken before anesthesia can cause problems such as choking or vomiting.

If you don't follow these rules, your child's surgery may be canceled.

Type of Food	Examples	Latest time you can eat or drink
Clear liquids 	<u>Liquids you can see through</u> such as water, apple juice, Pedialyte, other clear juices without pulp, plain jello	2 hours before you are told to arrive at the Surgery Center
Breast Milk		4 hours before you are told to arrive at the Surgery Center
ALL other foods and liquids 	Solids, milk, formula, candy, meat, bread, fried foods, cheeses, ice cream, mints or gum.	8 hours before you are told to arrive at the Surgery Center

Please give your child his/her usual prescribed medicines with a sip of water on the day of surgery unless instructed not to do so.



Call if you have any questions,
 The Preoperative Evaluation Center
 706-868-5676 ext 331
 Monday-Friday 9 AM-5 PM

ENT SURGERY CENTER OF AUGUSTA PRE-OP INSTRUCTIONS

Please read these instructions and be sure to follow them carefully:

If you have any questions feel free to call our office at 706-868-5676. Our surgery center is located at our Evans office, 340 North Belair Rd., in the back of the building.

- ___ 1. Make arrangements to have a responsible adult be with you to drive you home after surgery. You must have an adult stay with you for the first 24 hours after your surgery. A parent or legal guardian must accompany a minor.

- ___ 2. A nurse from the surgery center will contact you the day before surgery for your arrival time. For the safety of our employees, the door of the surgery center will not be unlocked until 6:30 am. Due to limited space, please limit family to two (2) people.

- ___ 3. Do not eat anything for at least eight (8) hours before your arrival time at the surgery center. You may have clear liquids (water, apple juice, Gatorade/pedialyte, tea or black coffee) up to two (2) hours before your scheduled time of arrival.

- ___ 4. If you routinely take prescription medications, you may do so until three (3) hours prior to your arrival time, unless you have been directed otherwise by your surgeon or anesthesiologist.

- ___ 5. Do not wear any make-up, nail polish, hairpins or jewelry to the surgery center. Do not bring money or valuables.

- ___ 6. Shower or bathe the night before or the morning of surgery. Do not use lotions or oils on the skin the night before or the morning of surgery. Deodorant is permitted.

- ___ 7. Notify the surgeon of any change in your physical condition (fever, cold, sore throat, etc.) before the surgery.

- ___ 8. Wear loose comfortable clothing and shoes that slip on easily. No jeans, pantyhose, high heels or boots. Do not wear contact lenses. You may bring socks to wear.

- ___ 9. Please do not take any aspirin products (Advil, Motrin, Aleve, Goody powders, etc.) as well as herbs and vitamins two (2) weeks prior to your surgery date.

- ___ 10. An anesthesiologist will talk to you on the day of your surgery and answer any questions you may have regarding anesthesia.

- ___ 11. Please bring a bottle or sippy cup for infants or small children for use after surgery.

- ___ 12. Please call your insurance company to find out the laboratory they use and please bring your insurance card with you on the day of surgery.

Advance Directive

An advance directive is a legal document, such as a living will or durable power of attorney, for healthcare recognized under State law. If you have executed an advance directive please bring it with you on the day of surgery.

___ I have an advance directive

___ I **do not** have an advance directive

SIGNATURE OF PATIENT/ LEGAL GUARDIAN

DATE / TIME

SIGNATURE OF NURSE

ENT SURGERY CENTER OF AUGUSTA LAB RELEASE FORM

Patient Name:
Date of Surgery:

ENT Surgery Center of Augusta uses Trinity for specimens and blood work. If this lab does not comply with your insurance company please circle the lab of your choice at the bottom of this form and your labs will be sent there. If you fail to choose a specific lab, your laboratory tests will be sent to Trinity.

PAYMENT POLICY: I understand that it is my responsibility to inform the ENT Surgery Center of Augusta of the lab that my insurance company covers. I also understand that I am personally responsible for payment of all charges, which are incurred for services rendered to me or the above name regardless of insurance coverage.

Please check the lab of your choice if you do not want your labs sent to Trinity:

- | | |
|--|---|
| <input type="checkbox"/> Mullins Lab | <input type="checkbox"/> Doctors Hospital |
| <input type="checkbox"/> University Hospital Lab | <input type="checkbox"/> Lab Corp: |
| <input type="checkbox"/> Quest | <input type="checkbox"/> Other: _____ |

SIGNATURE _____

DATE _____

**ENT SURGERY CENTER OF AUGUSTA
ANESTHESIA HISTORY & PHYSICAL ASSESSMENT**

HOME PHONE: _____ **Patient Label**
ALTERNATIVE #: _____
HEIGHT: _____ **WEIGHT:** _____ **AGE:** _____
RACE*: American Indian Asian Black Hispanic Pacific Islander White Multi-Racial
ALLERGIES: _____
TYPE OF REACTION: _____
SCHEDULED PROCEDURE: _____ **DATE:** _____
EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____
PHONE #: _____
WHO WILL BE WITH YOU THE DAY OF SURGERY: _____

LIST ALL MEDICATIONS & STRENGTHS YOU TAKE DAILY:
(INCLUDE EYE DROPS, INHALERS, VITAMINS, HERBAL SUPPLEMENTS, ASPIRIN, AND BIRTH CONTROL PILLS)

DRUG AND STRENGTH	LAST TAKEN	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL SURGERIES AND DATES:

SURGERY	DATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU CURRENTLY EXPERIENCING ANY PAIN? ____ YES ____ NO
IF YES, PLEASE DESCRIBE: _____

DATE OF LAST X-RAY: _____ NORMAL _____ ABNORMAL _____
DATE OF LAST EKG: _____ NORMAL _____ ABNORMAL _____
NAME OF YOUR FAMILY PHYSICIAN: _____ TELEPHONE # _____

* Requested by State of Georgia Department of Community Health

(CONTINUED ON BACK)

PLEASE CHECK ONE OF THE FOLLOWING: (PATIENT INFORMATION ONLY)

YES NO

- ____ 1. Any problems with prior anesthetics? If yes, please describe: _____
- ____ 2. Have you ever had fever after an anesthetic?
- ____ 3. Has any family member had problems with anesthetics, including malignant hyperthermia, paralysis, etc.?
- ____ 4. Do you smoke?
- ____ 5. Do you drink alcohol?
- ____ 6. Do you use any recreation drugs, including heroin, cocaine, marijuana, etc?
- ____ 7. Are you allergic to latex?
- ____ 8. Have you taken steroids over the past year?
- ____ 9. Can you climb 2 flights of stairs nonstop without getting chest pain or shortness of breath?
- ____ 10. Do you exercise? Type/how often? _____
- ____ 11. Have you ever had a blood transfusion? If yes, when? _____
- ____ 12. Could you be pregnant?
What is the date of your last menstrual period? _____
- ____ 13. Do you have any bleeding or clotting abnormalities including easy bruising or excessive vaginal bleeding?
- ____ 14. Do you have any implants? If yes, what type? _____
- ____ 15. Have you had any recent colds? If yes, when? _____
- ____ 16. Do you have loose teeth, chipped teeth, dentures, caps, crowns, bridgework, braces?
If yes, please list. _____
- ____ 17. Do you have difficulty or pain with opening your mouth widely or tilting your head back to look above you?
- ____ 18. Do you wear contact lenses or glasses?

DO YOU HAVE ANY OF THE FOLLOWING?

- ____ 1. Thyroid or goiter problems?
- ____ 2. Diabetes or epilepsy?
- ____ 3. Muscle weakness, paralysis, stroke?
- ____ 4. High blood pressure?
- ____ 5. Chest pain, angina?
- ____ 6. Heart disease, murmur, mitral valve prolapse?
- ____ 7. Lung disease, shortness of breath, chronic cough?
- ____ 8. Asthma, wheezing? Last attack: _____
- ____ 9. Kidney or bladder disease?
- ____ 10. Hepatitis, jaundice, cirrhosis, HIV positive?
- ____ 11. Ulcers?
- ____ 12. Hiatal hernia or reflux?
- ____ 13. Anemia or recent weight loss?
- ____ 14. Have you ever had nose or jaw surgery?
- ____ 15. Have you had any broken facial bones?
- ____ 16. Frequent headaches or dizzy spells?
- ____ 17. Any back problems, including surgeries, fractures, painful positions.
- ____ 18. Motion sickness?
- ____ 19. Have you ever taken Redux, Phen-Phen, or any other diet pill? Date _____

Patient/Responsible Party Signature _____

Date _____

Assessment reviewed, positive findings were discussed with patient/family.

Anesthesiologist's Signature: _____ Date: _____



Patient Rights and Responsibilities

The staff of the ENT Surgery Center of Augusta is pleased you have chosen our facility for your surgery. We encourage you to take an active role in managing your health. We can work together most effectively if you understand what to expect from us and what we can expect from you. Below is a summary of your rights and responsibilities as a patient.

As a patient you have the right to:

- Be treated with respect and dignity.
- Expect confidentiality of the information given to the Center.
- Expect reasonable fulfillment of requests made for medical services.
- Be informed concerning your procedure and a general orientation to our facility routine.
- Submit an Advance Directive (Legal document such as a Living Will/Durable Power of Attorney)
- Request consultation and/or transfer to another physician in the practice.
- Express concerns or grievances regarding your care with the staff, nurse manager, and/or your physician.

As a patient you have the responsibility to:

- Provide accurate personal information and subsequent changes in that information.
- Agree to pay for services rendered when requested to do so or discuss mitigating circumstances, which may necessitate a payment plan.
- Willingly abide by the corrective actions taken by the Center in case of default in the above responsibilities.
- Show respect for your fellow patients, the ENTSCA staff, and the Facility.
- Be punctual in keeping appointments or if an appointment is to be canceled, promptly notify the Center in order that the time may be released for another patient's use.

Questions or Concerns?

- We want you to feel that you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, the staff or the nurse manager.
- If your complaint is not resolved to your satisfaction you may obtain a Grievance Form from our receptionist. This assures that your complaint will be investigated by the Quality Improvement Coordinator of the surgery center.
- If you still feel that your grievance has not been properly addressed by the ENT Surgery Center of Augusta, you may contact:
Rhonda M. Meadows, MD Commissioner
Georgia Department of Community Health
2 Peachtree Street, NW Atlanta, GA 30303-3159
Phone: 404-656-0655
- Medicare patients may visit the website for the Office of the Medicare Beneficiary Ombudsman @ <http://www.cms.hhs.gov/center/ombudsman.asp>

The ENT Surgery Center of Augusta is an LLC, owned wholly by the physicians of Augusta ENT, PC under Georgia State law as a single specialty ambulatory surgery center, Permit No: 036-286