

AUGUSTA



ear • nose • throat

## PRE-OPERATIVE PEDIATRIC INFORMATION PACKET

Thank you for choosing Augusta ENT for your healthcare needs. Your child will be scheduled for surgery at the ENT Surgery Center of Augusta located at the back of our Evans office at 340 North Belair Road. This packet is your Pre-Operative information. Please read each page and follow the directions carefully.

### **Patient Notification** (For you to keep)

You **MUST** read this page **BEFORE** the date of your surgery. It informs you of your rights and responsibilities as a patient.

Please fill out, sign, and bring with you on the day of your surgery:

1. **Lab Release Form** – You may need to call the phone number on your insurance card or your caseworker to find out this information. This is to avoid sending anything to a lab that is not in your network, which would create unnecessary out-of-pocket expenses for you.
2. **Pre-op Instructions**
3. **Anesthesia History & Physical**

### **Eating and Drinking Rules** (For you to keep)

You will be given instructions over the phone about eating and drinking the day before your surgery. This page serves as another reminder of those rules.

Please call our office if you have any questions. (706) 868-5676, ext. 331

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### **Billing Information**

Your charges for the surgery center are separate from your doctor/surgeon and anesthesia.

You can expect to receive up to 4 bills for your visit:

1. Facility - The ENT Surgery Center of Augusta
2. Doctor - From the physician that performed the surgery.
3. Anesthesia - From the anesthesiologist that put you to sleep.
4. Pathology - If specimens were obtained. Your doctor will inform you and/or your family member after the procedure if specimens were sent to the lab.

It is the policy of this center to collect co-pays and/or deductibles prior to or on the day of surgery. You should receive a call from our business office if there will be any payment due prior to your surgery.

If you have any questions about billing please call (706) 868-5676 ext. 273 or ext. 333.



**PATIENT NOTIFICATION**  
ENT Surgery Center of Augusta  
340 North Belair Rd, Evans, GA 30809  
706-364-4040 Fax 706-364-8402

### **PATIENT RIGHTS**

The ENT Surgery Center would like to assure you of your rights and responsibilities as a patient.

You have a right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Personal and informational privacy, within the law.
- Information concerning your diagnosis, treatment & prognosis, to the degree known in a language or manner you understand, or to an individual designated by you or to a legally authorized individual as part of the informed consent process.
- Appropriate assessment and management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Know the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.

### **PATIENT COMPLAINT OR GRIEVANCE**

The ENT Surgery Center will promptly review, investigate & resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, we provide you with the following contact information:

ENT Surgery Center of Augusta  
340 North Belair Rd, Evans, GA 30809  
Attention: Keith Lynn, Administrator  
(Within 20 working days you will receive written notice of the status of your grievance from Mr. Lynn.)

Georgia Dept. of Community Health  
ATTN: Complaints Dept  
2 Peachtree Street, Suite 3100  
Atlanta, GA 30303-3142  
404-657-5726  
1-800-878-6442  
<http://ors.dhr.georgia.gov/portal/site/DHR-ORS>

All Medicare patients may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's web page at:

<http://www.cms.hhs.gov/center/ombudsman.asp>  
1-800-MED-ICARE

Revised 08/10/11

### **PATIENT RESPONSIBILITIES**

You are responsible for:

- Providing accurate complete information regarding your present health status (including past and present prescription, herbal, over the counter and supplement medications), past medical history, & for reporting any unexpected changes to the appropriate practitioner (s).
- Following the treatment plan recommended by the primary practitioner.
- Following the rules & regulations of the facility affecting patient care & conduct.
- In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- Be considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expeditiously as possible.

### **PRIVACY AND CONFIDENTIALITY**

The ENT Surgery Center of Augusta complies with federal HIPAA (Health Insurance Portability & Accountability Act) regulations to maintain the privacy of your health information.

### **ADVANCE DIRECTIVE**

The ENT Surgery Center of Augusta is not an acute care facility; therefore regardless of the contents of any advance directive or instructions from a health care surrogate or attorney, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures and transfer you to an acute care setting for further evaluation. Your agreement with this policy **does not** revoke or invalidate any current health care directives or health care power of attorney. If you have an Advance Directive, it is your responsibility to provide a copy to our center on the day of your procedure. Should you be taken to the hospital your copy will go with you. If you would like an Advance Directive you may request one from the front desk of the surgery center.

### **CONSULTATION**

The patient, at his/her own request and expense, has the right to consult with a specialist.

### **DISCLOSURE OF OWNERSHIP**

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 036-28.

# 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:**

Mullins Lab

Doctors Hospital

University Hospital Lab

Lab Corp

Quest

Trinity

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

# 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.

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**SIGNATURE OF PATIENT/ LEGAL GUARDIAN**

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**DATE / TIME**

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**SIGNATURE OF NURSE**

**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: \_\_\_\_\_



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