READ, FILL OUT, SIGN and Bring to Surgery

PRE- ADMISSION PACKET

WEST COAST CENTER FOR SURGERIES
653 CAMINO DE LOS MARES
SUITE 101
SAN CLEMENTE, CA 92673
(949) 545-6620

NOTE: THIS PACKET MUST BE COMPLETED AND BROUGHT WITH YOU ON THE DAY OF YOUR SURGERY. IF THIS INFORMATION IS NOT COMPLETE, YOUR SURGERY MAY BE RESCHEDULED.

WELCOME to West Coast Center for Surgeries, a multi specialty surgery center. We appreciate your choosing our surgery center for your outpatient surgery needs.

Enclosed are registration documents for you to read and complete. These documents include:

- Map and Directions to West Coast Center for Surgeries
- Statement to Permit Payment of Insurance Benefits
- Permission to Relay Information
- Notice of Privacy Practices
- Patient Rights
- Patient Responsibilities, Ownership, Compliments, Advanced Directive Policy
- Conditions for Treatment
- Patient Medication Information
- Medication Reconciliation

Please bring all completed and signed documents to WCCS on the day of your surgery appointment. All monies due are to be paid to a surgery coordinator 2-3 weeks prior to the surgery date.

Your surgery appointment is on _____/_____/_____.

Our nursing staff will call you 2 days before your appointment to confirm your arrival and surgery time.

We look forward to seeing you and appreciate your scheduling with West Coast Center for Surgeries. Should you have any questions, please feel free to call us at (949) 545-6620.

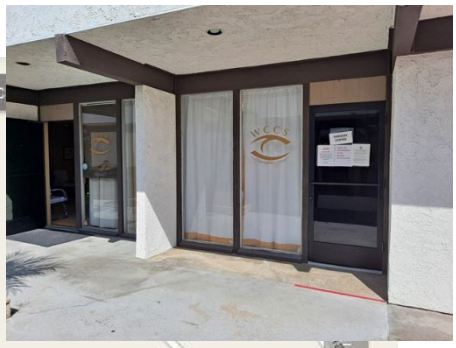
Sincerely,
West Coast Center for Surgeries

West Coast Center for Surgeries

WCCS
653 Camino de los Mares #101
San Clemente, CA 92673
(949) 489-2218

From the 5 Fwy South, exit Camino de Estrella and turn left. Travel approximately 1 mile (pass 4 signals) and turn into the parking lot for the San Clemente Professional Plaza. This is located directly across the street from the Old San Clemente Hospital. Walk towards Trestles Chiropractic and turn left into the first corridor.

From the 5Fwy North, exit Camino de Estrella and turn right. Travel approximately 1 mile (pass 4 signals) and turn into the parking lot for the San Clemente Professional Plaza. This is located directly across the street from the Old San Clemente Hospital. Walk towards Trestles Chiropractic and turn left into the first corridor.



WEST COAST CENTER FOR SURGERIES
653 Camino de los Mares, Suite 101
San Clemente, CA 92673
Phone (949) 545-6620 • Fax (949) 496-3604

STATEMENT TO PERMIT PAYMENTS OF INSURANCE BENEFITS

"I request that payment of authorized insurance benefits be made on my behalf to WEST COAST CENTER FOR SURGERIES. I further authorize payment be released to other providers required during the surgical procedures being performed on me this date. I authorize any holder of medical information about me to release to the insurance company or companies such information as required to determine these benefits or the benefits payable for related services until such time as I give further written notice."

I have received verbally and in writing;

- My Patient Rights
- My Responsibilities
- Physician Ownership Information
- Compliments/Grievance Policy
- Advance Directive Policy with Authority to Resuscitate

I wish to receive a copy of the California Health Care Directive form ☐ Yes ☐ No

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. **Some method of contact must be provided**, and as appropriate, information as to how payment will be handled.

I, _____, give permission for West Coast Center For Surgeries, Tayani Institute and DermaBare of Mission Viejo physicians and employees to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

Phone/ Email/ Online Patient Portal

Contact me regarding my appointments by telephone. YES ☐ NO ☐

Contact me regarding my test results by telephone. YES ☐ NO ☐

Leave messages on my answering machine / voice mail YES ☐ NO ☐

Information exchange by email and or use of our patient portal YES ☐ NO ☐

You may use the following telephone numbers:

Work: _____Home: _____Cell Phone: _____

You may leave messages with the following people (Print Names):

_____ _____

_____ _____

Or

Mail

☐ Send mail regarding appointments, my test results or my condition and treatment to the following address:

_____

_____

Signature: _____Date: _____Date of Birth: _____

(PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR)

Name: _____Relationship: _____

WEST COAST CENTER FOR SURGERIES
653 Camino de los Mares, Suite 101
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Notice of Privacy Practices (Protected Health Information)

All patient information including but not limited to written typed, faxed or electronic correspondence, billing, demographic and all medical records and charts will be physically and electronically protected in order to maintain patient privacy and confidentiality and to protect unauthorized access to that information.

All physicians and staff members will implement the following policies and procedures:

All patient information will be maintained in the medical record chart and the chart will be kept in a lockable file cabinet with lockable doors with limited key access.

Medical charts, notes, billing information, schedules and any other form of patient information will not be left within view of or accessible by unauthorized persons.

All physician and staff confidential conversations regarding patients are to take place, to the maximum extent possible, only in areas that cannot be overheard by unauthorized persons.

Computer data integrity will be maintained with firewall and virus protection software, regular backups of information and by limited access with password protection by only authorized personnel.

Patient medical information, photographs, or images will not be released without the written consent of the patient or legal guardian. Release of information for research, educational or diagnostic purposes will require the patient's written authorization.

Patient information may be released without prior consent for purposes such as treatment, to report abuse, neglect, domestic violence, public health risks, to obtain payment for treatment, communication with family members if necessary, or to report reactions to medications or products.

Patients have the right to inspect and receive a copy of the medical records and to request an amendment to their records. Although the health care provider has the right to deny inclusion of an amendment, the patient has the right to file a "Statement of Disagreement" which will then become part of the patient's record.

Patients at this facility are provided with this notice of privacy practices and will be asked to sign an acknowledgement of receipt of this notice. The signed acknowledgement will become part of the patient's medical records.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996, HIPAA, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient,

significant new rights to understand and control how your health information is used effective 4/13/03. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures or family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to lodge a complaint with the Privacy Officer.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for this surgery center as required by the federal Health Insurance Portability and Accountability Act.

_____ _____ _____

Patient Signature Date Time

West Coast Center for Surgeries

Medicare Pre-Notification provided prior to surgery.

PATIENT RIGHTS

Our patients have the right to:

1. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for his/her care.
2. Receive information from his/her physician about his/her illness, course of treatment and prospects for recovery in terms that he/she can understand.
3. Receive as much information about any proposed treatment or procedure as he/she may need, in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
4. Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
5. Full consideration of privacy concerning his/her medical care program; Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
6. Confidential treatment of all communications and records pertaining to his/her care and stay in the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
7. Reasonable responses to any reasonable request he/she may make for service.
8. Leave the surgery center even against the advice of his/her physician; Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
9. Be advised if the surgery center or personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects without compromising access to care.
10. Be informed by his/her physician, or a delegate of his/her physician, of the continuing health care requirements following his/her discharge from the surgery center.
11. Receive information regarding fees and payment schedule.
12. Examine and receive an explanation of his/her bill regardless of source of payment.
13. Know which surgery center rules and policies apply to his/her conduct while a patient.
14. Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
15. Have the right to refuse care, treatment, and services in accordance with law and regulation.
16. Have the right to be informed, and when appropriate their families, about the outcomes of care, treatment, and services, including unanticipated outcomes.
17. Have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
18. All personnel shall observe these patient rights.

Our center is dedicated to the provision of quality care and your opinion of the care provided is important to us. If you feel you have been treated unfairly, without respect, or treated inappropriately, please contact the administrative office at Phone 949-545-6620 or/and the office of Medicare Ombudsman at *www.cms.hhs.gov/center/**ombudsman**.asp***. 1-800-Medicare and /or local DHS Jackie Lincer you can also notify JCAHO Department of Quality monitoring regarding your experience with our center at 1-800-994-6610 or email compliant@jcaho.org.**

PATIENT RESPONSIBILITIES

The patient is responsible to:

1. Provide accurate and complete and accurate information concerning his/her present complaints, past medical history and any medications, including over-the-counter products and dietary supplements, allergies or sensitivities and other matters relating to his/her health.
2. Inform the center about any living will, medical power of attorney or other directive that could affects the patients care.
3. Make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
4. Follow the treatment plan established by his/her physician, including the instructions of nurses and other health professionals, as they carry out the physician's orders.
5. His/her actions should he/she refuses treatment or not follow his/her physician's orders.
6. Accept financial obligations
7. Have a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if requires by his/her provider.
8. Be respectful and considerate of all the rights of other patients and facility personnel.
9.

OWNERSHIP INFORMATION

The following physicians have a financial interest in this center:

RaminTayani, MD, Peter Joson, MD, David Gwynn, MD

COMPLIMENTS AND/OR COMPLAINTS

Dr. Tayani serves as the Medical Director of the Surgery Center. If you wish to speak with **Dr**. **Tayani** about the care provided at the Surgery Center, please contact him at 949-545-6620

Our center is dedicated to the provision of quality care and your opinion of the care provided is important to us. If you feel you have been treated unfairly, without respect, or treated inappropriately, please contact the administrative office at Phone **949-545-6620.** They will listen to you and direct your complement-complaint or observation to the appropriate individual and/or committee for resolution.

You can also notify ***JCAHO Department of Quality Monitoring*** regarding your experience with our center at 1-800-994-6610 or email compliant to. *jcaho.org* and *www.cms.hhs.gov/center/**ombudsman**.asp.*

ADVANVCED DIRECTIVE POLICY

Advanced Directive Policy

If the patient has an advanced directive, we ask if the advance directive contains a "DO NOT RESUSITATE" (DNR) clause. If the patient indicates they do have a DNR clause they are advised that the center will initiate life saving measures until transported to the hospital.

The patient is advised that they will waive the DNR portion of their advance directive when they sign the consent/permit prior to the procedure. The center will not perform surgery on patients that have advanced directives, unless they agree to be resuscitated.

If the patient does not waive the DNR, the procedure will be scheduled at the hospital.

CONDITIONS FOR TREATMENT AT WEST COAST CENTER FOR SURGERIES

1. **MEDICAL CARE.** During your surgery the patient must at all times be under the professional care of a doctor of the patient's own choosing. You acknowledge that the physicians working at the West Coast Center for surgeries. (The center") are not employees or agents of the Center, but are independent physicians who have been granted the privilege of using the Center facilities for the care and treatment of their patients. You acknowledge that no guarantees or representations have been made regarding the results or outcomes of the surgery at the Center.

2. **CONSENT TO TREATMENT.** You hereby request and voluntarily consent to the receipt of the medical services at the Center, including the diagnostic, laboratory, pathology, x-ray and imaging procedures and the administration of anesthesia judged necessary by the patient's attending physician and his or her assistants. The Center is hereby authorized to retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience, any specimens or tissue removed from the patient's body during the surgery.

3. **PERSONAL VALUABLES.** The Center will not be liable for the loss or damage to any personal property of the patient brought to the Center, except that which is properly deposited with the front office for safekeeping.

4. **CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND** HEALTH CARE **OPERATIONS.** The undersigned agrees that all records concerning this patient's surgery at the Center shall remain the property of the Center. The undersigned understands and agrees that such information is used for: (i) the provision and coordination of the patient's healthcare which may require disclosure of all or any portion of the patient's medical record information to the patient's attending physicians, to consulting physicians, and to other health care providers who have a legitimate need for such information; (ii) billing, claims management, medical data processing, reimbursement and for determining insurance coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of the patient's medical record which are necessary for payment of the patient's account; (iii) routine healthcare operations, including quality assurance, utilization review, medical peer review, internal auditing, accreditation, certification or licensing activities of the Center; and (iv) medical research and educational purposes. The undersigned acknowledgers that the patient has been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the NOTICE has been reviewed prior to the signing of this Consent. The undersigned understands that the Center has the right to change the NOTICE at any time. The undersigned agrees that he/she has the right to request the Center to restrict how the patient's health information is used or disclosed to carry out treatment, payment or healthcare operations, and understands that the Center is not required to agree to the requested restrictions. The undersigned acknowledges that he/she has the right to revoke this consent in writing, except to the extent that the Center has taken action in reliance thereon.

5. **PAYMENT RESPONSIBILITY.** The undersigned agrees and understands that the patient is responsible for the payment of all charges of the Center relating to services rendered by the Center to the patient that exceed any third party coverage, including any applicable coinsurance, payments and deductibles and all amounts which have been denied by any third party. The patient shall pay all costs of collection in connection with enforcement of this commitment, including attorneys' fees and court costs incurred by Center.

6. **ASSIGNMENT OF BENEFITS.** The patient hereby assigns to Center all benefits under any insurance policy, health plan, workers' compensation or other third party payor liable to the patient, in consideration of the services rendered by the Center. The patient also hereby assigns benefits to all physicians involved in the care of the patient while at the Center (the physicians billings will usually be billed separately from the Center's billings).

7. **AUTHORIZED REPRESENTATIVES TO PURSUE PAYMENT.** The patient hereby authorizes the Center, and the Center's attorneys, employees and other representatives to act as the authorized representatives of the patient in pursuing a benefit claim, or an appeal of an adverse benefit determination. This authorization includes the authority to

pursue appeals with the insurance company or other third party payor, to sue in court, to'arbitrate or mediate, to pursue administrative and/or regulatory appeals and to commence and prosecute any other legal actions that the Center and/or its attorneys or other advisors may deem necessary or appropriate.

8. **NURSING CARE**. The center provides general duty nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

9. **HOSPITAL TRANSFER.** There are risks and complications associated with both the surgical procedure(s) and the anesthesia. Your physician reserves the right to recommend and initiate the transfer of a patient to an appropriate hospital. This decision will be determined should his/her professional opinion of the patient's condition warrant such a transfer, or should the care of the patient begin to extend beyond the scope of our practice and staff capabilities here at the center.

10. **PHYSICIAN FINANCIAL INTEREST**.

The surgery center is an incorporation of physicians formed for the benefit of the community. The center wished to make you aware that Dr. Ramin Tayani the physician who referred you to the center, has an investment interest in the center, as do other surgeons who perform surgery here. As a matter of personal choice, you have the right to choose to have your recommended surgery at other locations instead of West Coast Center for Surgeries.

11. **Advance directive** is a written document, which communicates your health care wishes clearly.

There are two types of advance directive documents:

A Durable Power of Attorney for Health Care: Allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.

A Living Will or Health Care Directive: Allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

I have been explained the centers' policy on Advance Directives.

□ I DO have an Advance Directive
□ I have a "Do Not Resuscitate" Directive and agree to Resuscitation
□ I do NOT have an Advance Directive

This signed document implies consent for resuscitation and transfer to a higher level of care should the patient suffer a cardiac or respiratory arrest or other life-threatening situation.

12. **RECEIPT OF NOTICE OF PRIVACY PRACTICES**: I acknowledge receipt of facility's Notice of Privacy Practices (NPP). It provides information about how we may use and disclose your protected information. If we update our NPP, you may request a revised copy from the Privacy Officer or at the facilities administration office.

13. I, the undersigned, do hereby consent to the withdrawal and testing of a blood sample from my body to be tested for HIV/ (AIDS) and for other communicable disease, I understand that the withdrawal and testing of my blood will be done only if an employee or physician of the surgery center has had an accidental needle stick or mucous membrane exposure to my blood or a body fluid. I understand that these testing procedures and related reports will be done in a manner which protects my privacy and maintains my confidentiality. I understand that these tests will be performed at no cost to me. My initials here indicate my consent for Blood Drawn for Needle stick injury:

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

□ Patient unable to sign due to medical condition.

_____	_____	_____
Patients/Authorized Representative Signature	Date	Time
_____	_____	
Patients/Authorized Representative printed name	Witness	

WEST COAST CENTER FOR SURGERIES

PATIENT HEALTH HISTORY

Please complete the following information and bring it with you to West Coast Center for Surgeries the day of surgery

Name:_____ **Age:**_____ **Sex:** ❑ **Male** ❑ **Female**

Height:_____ **Weight:**_____ **Person taking you home:**_____ **Phone #:**_____

Do you or did you have any diseases involving the following: (Check Yes or No and Circle the disease)

YES	NO	
		Heart: (heart attack/congestive failure/chest pain/irregular beat/valve problems/rheumatic fever/surgery/other)
		Lungs: (asthma/bronchitis/wheezing/shortness of breath/ emphysema/TB/chest cold in the last six weeks/other)
		Kidneys: (dialysis/failure/infection/stones/others)
		Circulation: (high BP/phlebitis/clots/poor circulation/other)
		Diabetes: (diet controlled/pills/insulin)
		Thyroid: (under active/over active/other)
		Liver: (yellow jaudice/hepatitis/cirrhosis/mono/other)
		Nervous System: (stroke/convulsions/paralysis/parkinsonism/ multiple sclerosis/myasthenia gravis/other)
		Psychiatric: (anxiety attacks/schizophrenia/depression/other)
		Digestive: (hiatal hernia/reflux/ulcers/indigestion/other)
		Teeth/Airway: (false/loose/caps/bridges/braces/retainers/ sleep apnea/trouble opening mouth)
		Contact Lenses: (soft/hard/extended wear) Removed

YES	NO	
		Muscles/Joints: (neck/jaw/arthritis/scoliosis/other)
		Other Significant Medical History: (cancer/glaucoma/ sinusitis/other)
		Tobacco: (chew/smoke__packs/day____years/quit)
		Alcohol: (social _____ /daily _____ /quit _____)
		Street Drugs: (marijuana/cocaine/IV drugs)
		Blood Transfusions/Blood Products
		Any chance you are pregnant?
		Have you taken Prednisone/Steroids within the last six months?
		Blood Disorders
		Anesthesia: Have you had any problems with anesthesia in the past? Have any of your blood relatives had trouble with anesthesia? Do you have anything you want to discuss regarding your anesthesia?

OTHER: _____

MEDICATIONS: List all medications and dosages you presently take. Include any non-prescriptive, over-the-counter medications, herbal medications or vitamins, or any illegal drugs. PLEASE LIST ON MEDICATION RECONCILIATION **ALLERGIES:** Medications/ Latex/Other (please list below) _____

SURGICAL HISTORY: (Include all previous recent surgeries)

_____ Date _____

_____ Date _____

_____ Date _____

RN Reviewed:_____ Date:_____ Time:_____

West Coast Center for Surgeries

MEDICATION RECONCILIATION FORM

(Patient to complete shaded portion of form)

Patient Label

Allergies: ☐ NKDA ☐ Verified ☐ See attached list for extensive allergies

Medication_____ Reaction_____

_____ _____

_____ _____

Medication Information Obtained From:
☐ Patient ☐ Family member of patient ☐ Written list provided by patient

CURRENT HOME MEDICATION LIST
TO BE COMPLETED BY PATIENT PRE-OPERATIVELY
(Including: Prescription, Over the Counter, Herbal Remedies, Vitamins, Dietary Supplements)

TO BE COMPLETED BY NURSE/ PHYSICIAN ON DAY OF SURGERY

Medication/Dosage	Taken For	How Is It Taken (oral, inject., patch, etc.)	How Often Is It Taken	Taken in AM or PM	When Last Dose Was Taken	Continue After Discharge	Check with Prescribing Physician
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐
						☐ Yes ☐ No	☐

Patient Acknowledgement:
- I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have questions about my home medications, I will call the doctor who prescribed them.
- I understand that my medication list may be shared with my other physicians unless I decline. ☐ I decline.

Patient (designee) Signature:_____ Date:_____

- **Current home medication list has been reviewed with patient pre-operatively.**

Staff Signature:_____ Date/Time:_____

NEW MEDICATIONS TO BEGIN TAKING

Medication/Dose	How Is It Taken	How Often Is It Taken	Rx Given at	Med Info Given
			☐ Pre-Op ☐ DOS	☐ Yes
			☐ Pre-Op ☐ DOS	☐ Yes
			☐ Pre-Op ☐ DOS	☐ Yes

Staff Signature:_____ **Date/Time:**_____

Physician review of Medications:_____ Time/Date:_____ Continue_____ Check with prescribing:_____