PATIENT SELECTION & HEALTH INFORMATION SHEET

OBGYN NAME_____ PRACTICE NAME & LOCATION:_____

DATE, TIME AND TYPE OF SCHEDULED SURGERY:_____

PARAGON AMBULATORY HEALTH RESOURCES 214-389-3030 FAX 214-987-0897

VERSION.7.6.10

LEEP

NAME_____

Date & Time of surgery_____

Age____ Birthdate_____

Preferred name_____

CELL#_____

EMERG CONTACT_____

_____

Primary care physician_____

Date of last exam_____

Results of last exam_____

Date & Results of last lab work____

_____

Height_____ Weight_____

Insurance Company:_____

Could you be Pregnant?_____

alcoholic drinks per week_____

Recreational drug use_____

Problems w/ Anesthesia_____

Diet pill use_____

Recent Draining Sinuses_____

Caffeine per day_____

Any "colds" last 1 month_____

ALLERGIES	NO	YES	REACTION
LATEX			
IODINE			
CONTRAST DYE			
ANESTHESIA			
DRUGS:			
1			
2			
3			
4			

Do You Have a History Of:	YES	NO
Anemia		
Uterine Surgery		
Uterine Infections		
Pelvic Inflammatory Dz		
STD's		
Bleeding Disorder		
Clotting Disorder		
Coughing		
Seizures		
High Blood Pressure		
Partial Plates		
Dentures		
Asthma		
Shortness of Breath		
Smoking		
Recent URI		
Acid Reflux/Heartburn		
Ulcers		
Hiatal Hernia		
Arthritis		
Joint Pain		
Depression		
Anxiety		
Panic Attacks		
Chemical Dependency Hx		
AA Member		
Cancer		
Dizziness/Fainting		
Numbness/Tingling		
Implants		
Prosthesis		
Sickle Cell Disease		
Hepatitis		
AIDS		
Lupus		
Autoimmune Disease		
Blood in Urine		
Kidney Stones		
Thyroid Problems		
Pituitary Problems		
Headaches/Migraines		
Vision Problems		
Glaucoma		
Recent Contagious Illness		
Contagious Illness Exposure		
Irregular Heartbeat		
Rapid Heartbeat		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea/Constipation		
Diabetes		
Skin problems/Bruising		
Muscle spasms/Weakness		
Fatigue/Low Energy		

Meds, herbs, diet meds, inhalers, vitamins, patches:

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

Personal Preferences:

Music_____

---END OF PATIENT PORTION---

NOTE:

PLEASE FAX THIS COMPLETED FORM TO PARAGON AT LEAST THE DAY BEFORE SURGERY. 214.987.0897

ABNORMAL LAB RESULTS:

H/H if pt has a hx of recent symptomatic anemia.

BMI:_____

BODY MASS INDEX

BMI=KG/M^2

HEIGHT/OBESITY[3]/MORBID[4]

	30	35
4'10"	65	76
4'11"	68	79
5'0"	70	81
5'1"	72	84
5'2"	75	87
5'3"	77	90
5'4"	80	93
5'5"	82	96
5'6"	85	99
5'7"	87	102
5'8"	90	105
5'9"	92	108
5'10"	95	111
5'11"	98	114
6'0"	101	118
6'1"	104	120
6'2"	106	124
6'3"	109	127

LEEP

FASTING GUIDELINES FOR OFFICE SURGERY 6.7.09

VER6.7.09

UNTIL TWO HOURS

BEFORE YOUR SCHEDULED SURGERY START TIME YOU MAY HAVE THE FOLLOWING LIQUIDS:

COFFEE

(SUGAR, SWEETENER, NON-DAIRY CREAMER OK)

TEA

(SUGAR, SWEETENER, NON-DAIRY CREAMER OK)

SOFT DRINKS:

(COKE, SPRITE, GINGER ALE, ETC).

WATER

FRUIT JUICES ***WITHOUT*** PULP

(SUCH AS APPLE, CRANBERRY OR GRAPE)

PLAIN JELLO

(NO FRUIT, NO DAIRY)

CLEAR CHICKEN BROTH

(SWANSON'S CANNED IS OK)

DO NOT DRINK MILK OR DAIRY PRODUCTS

***DO NOT DRINK JUICE WITH PULP**

(MOST ORANGE JUICE HAS PULP)

UNTIL SIX HOURS

BEFORE YOUR AFTERNOON SURGERY START TIME YOU MAY FOLLOW THE ABOVE DIRECTIONS FOR LIQUIDS

PLUS.... A LIGHT BREAKFAST OF:ONE OR TWO PIECES OF DRY TOAST WITH JAM OR JELLY ONLY AND ONE POACHED OR BOILED EGG (NO OIL)

OR: 2 PANCAKES WITH SYRUP ONLY (NO BUTTER).

UNTIL EIGHT HOURS

BEFORE YOUR SURGERY

YOU MAY HAVE: A NORMAL BREAKFAST

FOLLOWED BY: ALL OF THE ABOVE LIQUIDS

(UNTIL TWO HOURS BEFORE SURGERY)

LEEP

OFFICE SURGERY
DISCLOSURE AND CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical procedure to be used to treat your condition so that you may make the decision whether or not to undergo the procedure after knowing the risks, hazards and requirements involved. You have the right to be charged a reasonable and fair amount for the procedure used. You have the right to be billed fairly using a system that allows you to understand the billing process and the bills themselves. You have the right as a patient to be treated with compassion, kindness, respect and warm understanding. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent for the procedure.

- I voluntarily request Dr. Snead as my OB/GYN and such associates, technical assistants and other health care providers as may be deemed necessary, to treat my condition which has been explained to me as:

Abnormal pap

- I understand that the following surgical and diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:

LEEP - Loop Electrical Excision Procedure

- I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

- I do____ do not____ consent to the use of blood and blood products in the rare occasion that they would be necessary. I also realize that the usual risks and hazards may occur in connection with this particular procedure, including fever, transfusion reactions, kidney failure, heart failure, infections and anemia.

-There are risks and hazards associated with the performance of office surgery procedures. As with many surgical procedures there is a risk for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death.

- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

DATE:_____ TIME:_____ A.M./P.M Patient Signature_____

Witness Name & Signature:_____

Address:_____

The risks, benefits, and alternatives to the procedure have been explained and the patient understands and agrees.

Surgeon signature: _____ Date:_____

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LEEP

DISCLOSURE AND CONSENT FOR ANESTHESIA

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended anesthetic and surgical procedure to be used to treat your condition so that you may make the decision whether or not to undergo the procedure after knowing the risks, hazards and requirements involved. You have the right to be charged a reasonable and fair amount. You have the right to be billed fairly using a system that allows you to understand the billing process and the bills themselves. You have the right as a patient to be treated with compassion, kindness, respect and warm understanding. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent for the procedure and anesthesia.

- I voluntarily request my anesthesiologist to provide anesthetic care for my procedure which has been explained to me as:

IV GENERAL ANESTHESIA

- I understand that anesthesia services and equipment will be provided to me by Paragon.

- I do____ do not____ consent to the use of blood and blood products in the rare occasion that they would be necessary. I also realize that risks and hazards may occur in connection with this particular procedure, including fever, transfusion reactions, kidney failure, heart failure, infections and anemia.

-I understand that anesthesia involves risks and hazards, but **I (WE) REQUEST THE USE OF ANESTHETICS FOR THE RELIEF AND PROTECTION FROM PAIN DURING THE PLANNED AND ANY ADDITIONAL PROCEDURES.** I (we) realize that the anesthesia may have to be changed possibly without explanation to me, and that anesthesia providers may also change without warning.

- I understand that certain complications may result from the use of anesthesia, including respiratory problems, drug reactions, paralysis, damage to vocal cords, teeth or eyes, infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death.

-I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment of that condition, risks of non-treatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information to give this informed consent.

- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

DATE:_____ TIME:_____A.M./P.M Patient Signature_____

Witness Name & Signature:_____

Address:_____

The risks, benefits, and alternatives to the procedure have been explained and the patient understands and agrees.

Anesthesiologist signature:_____Date:_____

LEEP – Loop Electrical Excision Procedure

Patient Discharge Instructions

Recovery from any surgery differs with each individual. Please plan to rest at home the day of surgery. Although some individuals may leave the hospital or office feeling quite well and immediately resume their normal activities, others experience some minor discomforts.

1. Such discomforts may include the following: Soreness around the vagina and/or cramping is expected. You may be given a prescription for pain medication prior to discharge or pain medications may be called in. Do not feel obligated to use the prescription if acetaminophen (Tylenol) or ibuprofen (Advil, Motrin) is sufficient. If you are cramping on the way home, fill your pain medication prescription as soon as possible and follow the directions on the bottle. Remember that narcotic pain pills can cause nausea. Call Dr. Snead's office 817-741-9663 if you are unable to control your pain.
2. Nausea is possible. If you experience nausea at home, take only clear liquids. When you begin to feel better, slowly start adding solid foods. If your nausea persists, please call Dr. Snead's office 817-741-9663 (or your Anesthesiologist's office at 214-369-3030 if needed).
3. Varying amounts of vaginal bleeding after an LEEP procedure are expected. You may experience some degree of vaginal bleeding or watery discharge. You may also notice some vaginal passage of pieces of tissue. Bleeding that is heavier than a normal period should be reported. Worsening pain should always be reported.
4. No sex, no baths, no swimming, no tampons, and no heavy lifting greater than 10 pounds for two weeks AND until cleared after your post-op visit. Light exercise is ok as tolerated.

Please call Dr. Snead's office if:

1. You develop a temperature greater than 100.4 F; or
2. Your vaginal bleeding exceeds that of a normal period or the amount you and your OB/GYN expect; or
3. You develop a greenish or foul smelling vaginal discharge; or
4. You have uncontrolled or worsening pain; or
5. You develop pain after the initial surgical pain subsides; or
6. You are concerned or have questions.
7. Please call 911 in an emergency.

Patient Name; _____ DOB: _____

Patient Signature: _____

SCAN AND RETURN TO PATIENT