# Eye Surgery Packet

**This packet contains:**

- 17461 Informed Consent for Cataract Surgery (9/2013)
- 17466 Patient Evaluation Form (10/17/2013)
- M-1708-212 Anesthesia - Routine (4/22/2011)
- 17199 History and Physical (2/2015)
- M-1708-120 Cataract Removal (4/13/2011)
- 17495 Post-Operative / Procedure Note for Cataract Surgery (11/2013)

**McLaren Flint**

FLINT, MICHIGAN 48532

# INFORMED CONSENT FOR CATARACT SURGERY

1. I have been told by my physician, that my present condition or conditions may effectively be treated by the following procedure(s)

**☐ Left Eye ☐ Right Eye removal of cataract with insertion of intraocular lens prosthesis**

I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I have been told that during the course of the described procedure(s), unforeseen conditions may be discovered that necessitate an extension of the original procedure(s) or different procedures(s) than those described in Paragraph 1. I authorize the above physician, his associates and assistants, to perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted in this Paragraph 2 shall extend to treating all conditions that require treatment and are not known to the physician at the time the original procedure(s) is commenced.

3. I am aware that McLaren Flint is a resident teaching facility and that physician residents will be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.

4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s): ( ) regular blood or blood products from the Blood Bank; ( ) autologous blood only (blood I have given; ( ) designated (directed) donations only; ( ) no blood products. In the absence of a sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.

5. I agree to the use of anesthesia and/ or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.

6. I hereby authorize McLaren Flint to retain, preserve, and use for scientific or teaching purposes or dispose of, at its discretion, any specimen or tissue taken from my body.

7. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s) herein authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associated with the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.

8. I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

_______________________________________ Date/Time ______________________

(Signature of Patient)

(If patient is unable to sign or is a minor, complete the following:)
Patient is unable to sign because :

_____________________________________________________________________

_______________________________ _______________________________

(Witness) Authorized Patient Representative

I, herby attest to providing information regarding the patient's risks, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure.

_______________________________________ Date/Time ______________________

Signature of Physician

_______________________________________ Date/Time ______________________

Anesthesia Provider Signature

**INFORMED CONSENT FOR CATARACT SURGERY**

820b

17461 **Rev. (9/13)**

PT.

MR.#/P.M.

DR.

# McLaren Flint

Flint, Michigan 48532

**PATIENT EVALUATION FORM**

**PLEASE COMPLETE ALL HISTORY INFORMATION IN BLACK INK AND RETURN BY MAIL OR FAX UPON RECEIPT**

Patient Name: ______________________________

Surgery/Procedure ____________________ Reason for: ____________________

History of Surgical Procedures ______________________________

______________________________

Height ______ Weight ________ BMI ________

Primary Care Physician ______________________________ Phone ____________

Cardiologist ______________________________ Phone ____________

**Allergies & Reactions** ☐ No Known Allergies ☐ Latex ☐ Tape ☐ Shellfish ☐ Eggs ☐ Peanuts

______________________________

| NEUROLOGICAL | YES | NO |
|---|---|---|
| Seizures | ☐ | ☐ |
| Stroke/TIA/Mini Stroke | ☐ | ☐ |
| Numbness or Tingling | ☐ | ☐ |
| Fainting spells | ☐ | ☐ |
| Neuromuscular diseases | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Chronic pain / Fibromyalgia | ☐ | ☐ |

Comments: ____________________

| ENT | YES | NO |
|---|---|---|
| Loose, Chipped, or Missing Teeth | ☐ | ☐ |
| Dentures or Partials | ☐ | ☐ |
| Problems Opening or Closing your mouth | ☐ | ☐ |
| Difficulty moving your neck | ☐ | ☐ |

Comments: ____________________

| LUNGS | YES | NO |
|---|---|---|
| * Do you require supplemental oxygen 24 hours a day? | ☐ | ☐ |
| Asthma, Cough, Cold, or Wheezing | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| COPD | ☐ | ☐ |
| *Sleep Apnea; use CPAP/BiPAP Machine | ☐ | ☐ |
| Smoker: amt: ________ yrs. ________ | ☐ | ☐ |

Comments: ____________________

| CARDIAC | YES | NO |
|---|---|---|
| * Do you get short of breath or have chest pains when; climbing a flight of stairs, doing light housework or other activities of daily living? | ☐ | ☐ |
| * Have you been hospitalized in the last 3 months for congestive heart failure, heart attack or an angioplasty? | ☐ | ☐ |
| * Has there been a decrease in activity in the last 3 months? | ☐ | ☐ |
| * Chest pain or Angina (related to your heart) | ☐ | ☐ |
| Heart surgery; bypass or Valve replacement | ☐ | ☐ |
| Arrhythmias, Pacemaker, or AICD | ☐ | ☐ |
| Heart Cath., Stents, Stress Test | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |

Comments: ____________________

| GASTROINTESTINAL | YES | NO |
|---|---|---|
| GERD or Reflux | ☐ | ☐ |
| Hiatal Hernia or Ulcer | ☐ | ☐ |
| Cirrhosis | ☐ | ☐ |

Comments: ____________________

| ENDOCRINE/METABOLIC | YES | NO |
|---|---|---|
| * Kidney problems or Dialysis | ☐ | ☐ |
| Diabetes Type__________ | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ |

Comments: ____________________

| MUSCULOSKELETAL | YES | NO |
|---|---|---|
| Arthritis | ☐ | ☐ |
| * Muscle disease/Muscular Dystrophy | ☐ | ☐ |
| Limitation in movement | ☐ | ☐ |

Comments: ____________________

| COMMUNICABLE DISEASES | YES | NO |
|---|---|---|
| Do you have any signs of infection; fever, open wounds, recent flu or upper respiratory infection? | ☐ | ☐ |
| Do you have difficulty fighting off infection due to a chronic condition? | ☐ | ☐ |
| Are you being treated for any contagious diseases? | ☐ | ☐ |
| *MRSA | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Hepatitis What type __________ | ☐ | ☐ |

Comments: ____________________

| ANESTHESIA | YES | NO |
|---|---|---|
| *Difficult Intubation | ☐ | ☐ |
| Nausea or vomiting | ☐ | ☐ |
| Family/Personal History of Malignant Hyperthermia | ☐ | ☐ |

Comments: ____________________

| ALCOHOL USE | YES | NO |
|---|---|---|
| Frequency:______________ | ☐ | ☐ |
| Substance Abuse | ☐ | ☐ |

Comments: ____________________

| OTHER | YES | NO | |
|---|---|---|---|
| Bleeding, Anemia, or Sickle Cell disease | ☐ | ☐ | |
| *Are you Pregnant? | ☐ | ☐ | |
| Last Menstrual Cycle______________ | ☐ | ☐ | ☐ N/A |

Comments: ____________________

______________________________

Surgeon/Gastroenterologist Signature:

______________________________

Date:__________ Time:__________

PT.

MR.#/RM.

DR.

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McLaren Flint
Flint, Michigan 48532

# PREOP INSTRUCTIONS

☐ Reviewed with patient/caretaker/driver:

( ) Arrival Time ____________________
( ) NPO after______________________NO gum, mints, candy or water!
( ) Medication to take morning of surgery with sip of water, See Med Rec Form
( ) Limit Visitors to 1-2
( ) Responsible person to drive home, provide 24 hours of care, Length of stay ________
( ) Questions answered, understanding verbalized
( ) Dress Comfortably, No jewelry, make up, or valuables, remove contact lenses and body piercing
( ) Patient Rights & Responsibility

( ) No shaving/depilatory cream on surgery site 24 hrs prior
( ) Shower with antimicrobial soap morning of surgery
( ) Bring photo ID, insurance card
( ) Bring CPAP, Inhalers, Insulin
( ) Directions to facility offered
( ) Ownership Information
( ) DPOA / Living Will
( ) Comfort measure for peds (Bottle / Pacifier)
Notes:______________________________________________
______________________________________________________

**PAt RN Signature:** __________________________ **Date/t ime:**__________________

| **Pre Op Vital Signs** | BP: | P: | Resp: | SpO2: | Temp: | NPO Since: | Pain Scale |
|---|---|---|---|---|---|---|---|
| **ASA Rating** | 1 2 3 4 5 | ☐ Potential Difficult Intubation | | | | | |
| **Mallampati** | I II III IV | Poor Dentition ☐ Yes ☐ No | | | **Anesthesia Plan:** GA SP Epi Block MAC | | |

Anesthesia plan, risks, and benefits discussed with: ☐ Patient ☐ Parent ☐ Guardian

Comments:

| **Systemic Review** | Unremarkable | Abnormal Finding |
|---|---|---|
| Mental Status (Orientated x 3) | | |
| Nervous System | | |
| Cardiovascular | | |
| Respiratory | | |
| Gastrointestinal | | |
| Genitourinary | | |
| Musculoskeletal | | |
| Other | | |
| **Physical Exam** | Unremarkable | Abnormal Finding |
| HEENT | | |
| Heart | | |
| Lungs | | |
| Abdomen | | |
| Other / General Condition | | |

**Reviewed by:**

**CRNA**_____________________________________________ **Date/t ime** __________________________
**Anesthesiologist** ___________________________________ **Date/t ime** __________________________

| History of Present Illness / Pre-Op Diagnosis | |
|---|---|
| Plan / Treatment | |

By signing this form, I verify that the information on this assessment is current and there are no changes in the patients medical or surgical history for the 30 days. If needed, additional information may be obtained at the office.

Surgeon/Gastroenterologist Signature:_______________________________________________ Date:___________Time:____________

PT.
MR.#/RM.
DR.

## McLaren Flint

## ANESTHESIA - ROUTINE

**ORDERS** **ALLERGIES: See Medication Reconciliation Form**

1. **Pre Op Holding Routine Orders for all Patients**
   a. Oxygen PRN for saturations less than 94% after sedation or on Room Air
   b. IV start LR 1000 mL ( 500 mL for eye, EDG, and pedicatirc patients) at 10 mL / hour – offer with subcutaneous 1% Xylocaine.
   NS 500 mL at 10 mL / hour for Dialysis Patients
2. **Diabetic Patients**
   a. No Insulin a. m. of surgery
   b. Perform Glucometer / FBS
   c. Report FBS less than 70 or greater than 300
3. **General Anesthesia Patients**
   a. Greater than 18 years with DM, Obesity, GERD or reflux to receive: HOLD meds
   ☒ Famotidine (PEPCID) 20 mg PO with sip of $H_2O$ and
   ☒ Metoclopramide (REGLAN) 10 mg with sip of $H_2O$
   b. History of motion sickness or nausea and vomiting give
   ☒ Dimenhydrinate (DRAMAMINE) 50 mg PO on admission
4. **Colons and EGD's with GERD** give
   ☒ Citric Acid/Sodium Citrate (BICTRA) 30 mL PO, hold if reflux meds taken that day
5. **POHA Medications:**

☐ Famotidine (PEPCID) 20 mg PO or IVP
☐ Metoclopramide (REGLAN) 10 mg PO or IVP
☐ Ondansetron (ZOFRAN) _________ mg IVP
☐ Dimenhydrinate (DRAMAMINE) ______ mg PO
☐ Dexamethasone (DECADRON) ______ mg IVP N&V
☐ Hydrocoritsone Sodium (SOLU CORTEF) ____ mg IVP
☐ Labetalol ______ mg IVP
☐ Gabapentin (NEURONTIN) 300 mg PO
☐ Ibuprofen (MOTRIN) 600 mg PO Pain scale 1 - 3
☐ Celecoxib (CELEBREX) 200 mg PO
☐ Acetaminophen (TYLENOL) 500 mg PO Pain scale 1-3
☐ Citric Acid/Sodium Citrate (BICTRA) 30 mL PO
☐ Midazolam (VERSED) _______mg IVP anxiety
☐ Midazolam (VERSED) Syrup _______mg PO anxiety
☐ Fentanyl _______ microgram IVP
☐ Glycopyrrolate (ROBINUL) ______ mg IVP
☐ Other:___________________

**PreOp RN Signature:________________Date (required)______Time (required)_____**

6. **Post Anesthesia Orders:**
   a. $O_2$ per nasal cannula or face mask (iterate to keep saturations greater then 94% or at pre op baseline
   b. Titrate IV for desired effect
   c. Perform blood glucose test on Insulin dependent diabetics. (if greater than on hours since PreOp test.
   d. ☒ Cepacol Lozenges PRN for sore throat
   e. Discharge to home when criteria met and anesthesia approved.
7. **PACU PRN Medications:**

☐ Morphine Sulfate ______mg IVP every ___ minutes, total of ___mg every 2 hours
☐ Albuterol Breathing treatment
☐ Meperidine (DEMEROL) _____ mg IVP every ______ minutes, total of ______ mg
☐ Meperidine (DEMEROL) ______ mg IM
☐ Hydromorphone (DILAUDID) _____ mg IVP every _______ minutes, total of ______ mg
☐ Fentanyl _______ microgram IVP every ___ minutes, total of ___ micrograms every 2 hours for pain
☐ KetorolacTromethamine (TORADOL) _____mg IV / IM pain
☐ Ibuprofen (MOTRIN) _____ mg according to body weight pain
☐ Acetaminophen (TYLENOL) plain child suspension _____ mg PO pain
☐ Acetaminophen (TYLENOL) with codeine elixir _____ mg PO pain
☐ Droperidol (INAPSINE) 0.625 mg IV for nausea and vomiting may repeat in 30 minutes times 1
☐ Midazolam (VERSED) _______mg IVP anxiety
☐ Ephedrine _____ mg IV, IM
☐ Other meds:___________________________________________

Physician Signature:________________________________Date (required) __________Time (required)_______

PACU RN Signature:________________________________Date (required) __________Time (required)_______



**PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE**

M – 1708 – 212

640B

Patient Label

**McLaren Flint**
FLINT, MICHIGAN 48532

Date ______________________

## HISTORY & PHYSICAL

Patient ________________________________ Physician ________________________________

Chief Complaint ________________________________________________

**HISTORY**
Present Illness ________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

Allergies ________________________________________________

Current Medications ________________________________________________

________________________________________________

Past Medical History (check √ if present) or ☐ None

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
  Date: ______________
- ☐ Irregular Heart Beat
- Heart Failure
  - ☐ Congestive ☐ Systolic
  - ☐ Diastolic
- ☐ Peripheral Vascular Disease
- ☐ Murmur
- ☐ Pacemaker/ICD
- ☐ COPD
- ☐ Asthma
- ☐ Tuberculosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Ulcers
- ☐ CVA
- ☐ Transient Ischemic Attack
- ☐ Seizures
- Diabetes Mellitus
  - ☐ Type I
  - ☐ Type II
- Thyroid
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Bleeding Disorders
- _______ Pregnancies
- _______ Deliveries
- ☐ Other
  ______________________________

Past Surgical History ________________________________________________

________________________________________________

Social History

- ☐ Occupation ________________________________
- ☐ Smoking ________________________ ☐ Drugs ________________________
- ☐ Alcohol ________________________ ☐ Abuse (Psychosocial) ________________

Family History

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Malignant Hyperthermia

Review of Systems (check √ if present) or ☐ None

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Visual Disturbance
- ☐ Hearing Problems
- ☐ Light-headedness
- ☐ Altered Bowel Habits
- ☐ Altered Bladder Habits
- ☐ Dyspepsia/Dysphagia
- ☐ Anorexia/Weight Loss
- ☐ Fatigue/Weakness
- ☐ Weakness in Extremities

PT.

MR.#/RM.

DR.

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History & Physical

**PHYSICAL (Explain any abnormalities under "Other"):**

Vital Signs: ☐ Reviewed ☐ Other ______

HEENT: ☐ Normal ☐ Other ______

Neck: ☐ Normal ☐ Other ______

Breast: ☐ Normal ☐ N/A ☐ Other ______

Thorax: ☐ Normal ☐ Other ______

Heart: ☐ Normal ☐ Other ______

Lungs: ☐ Normal ☐ Other ______

Abdomen: ☐ Normal ☐ Other ______

Genitalia: ☐ Normal ☐ N/A ☐ Other ______

Pelvic: ☐ Normal ☐ N/A ☐ Other ______

Rectal: ☐ Normal ☐ N/A ☐ Other ______

Extremities: ☐ Normal ☐ Other ______

Neuro: ☐ Normal ☐ Other ______

**Pertinent Labs & X-Rays:**

______

______

______

**Provisional Diagnosis / Plan of Treatment:**

______

______

______

______

______

For Breast Patients only: Reconstructive Surgery Consultation ☐ Yes ☐ No

(Place corresponding order in CPOE)

Date: ______ Time: ______ Physician Signature ______

PT.

MR.#/RM.

DR

**McLaren Flint**

# CATARACT REMOVAL

## Pre – Operative Orders:

1. Pre Admission Testing: Follow anesthesia guidelines for testing
   Patient may remain on their blood thinners
2. Upon arrival: Prep the Operative eye with 1 gtt Proparacaine 0.5%
3. Draw up 0.25 mL in a syringe for EACH patient of the following mixture prepared in a STERILE cup: (Enough mixture for 11 patients)

   1 dram (5 mL) of Xylocaine 2% Jelly
   4 gtts 10% AK Dilate
   4 gtts 0.5% Acular
   4 gtts 1% Cyclogel
   4 gtts 1% Tropicamide / Mydriacyl
   4 gtts 0.3 Zymar

   If not ALLERGIC, instill approximately 0.25 mL into the inferior cul-de-sac, and have patient keep eye closed while the medication takes effect.

4. If eye is not dilating after 20 minutes, may instill AK Dilate 10% 1 gtt prior to the procedure.
5. May use eye gtts (see other side) if gel mixture is unavailable.

Orders Noted By:__________________________________ Date (required) __________ Time (required) _____________

## Intra-Operative Orders:

1. Betadine 5% 1 gtt in cul-de- sac 3 minutes prior to incision.

Orders Noted By:__________________________________ Date (required) __________ Time (required) _____________

## Post- Operative Orders:

1. Resume all usual medications, begin Post Op eye gtts as instructed
2. Acetaminophen (TYLENOL) 500 mg 2 tags PO for pain
3. Discharge per Anesthesia Protocol

Orders Noted By:__________________________________ Date (required) __________ Time (required) _____________

Physician Signature:_______________________________ Date (required) __________ Time (required) _____________


Revised 4/13/2011

**PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE**

M – 1708 – 120

640B

Patient Label

**McLAREN FLINT**
**Flint, Michigan**

## POST-OPERATIVE/PROCEDURE NOTE FOR CATARACT SURGERY

**NOTATIONS**
**All Bold Elements REQUIRED by CMS & Joint Commission. Please Fully Complete.**

Pre – Operative Diagnosis: ☐ Left Eye Cataract ☐ Right Eye Cataract

**Post – Operative Diagnosis:** ☐ Left Eye Cataract ☐ Right Eye Cataract

**Procedure(s) Performed:** ☐ Left Eye ☐ Right Eye

Removal of cataract with insertion of intraocular lens prosthesis.

**Physician/Surgeon(s):**

☐ Dr. Aggarwal ☐ Dr. Alrawi
☐ Dr. Cukrowski ☐ Dr. Diskin ☐ Dr. Herzog
☐ Dr. Keoleian ☐ Dr. McNally ☐ Dr. Rohr
☐ Dr. Ryan ☐ Dr. Stack ☐ Dr. Waters

**Assistant(s):** ☐ None

**No Specimens unless noted:** ________

**No Blood loss unless noted:** ________

**Findings:**
☐ Left Eye Cataract ☐ Right Eye Cataract

Anesthesia: ☐ General
☐ Local
☐ IV Sedation

Complications:
☐ No Complications Unless Noted__________________

Teaching Physician Addendum:

**Physician's Signature:** ____________________________ **Date/Time:** _________________

**POST-OPERATIVE/PROCEDURE NOTE**
**FOR CATARACT SURGERY**
17495 11/13

180b

PT.

MR.#/P.M.

DR.