Your best PATHWAY to HEALTH

Surgery Referral Form
Outpatient Procedures

Patient Information

Patient Name _____ Date of birth ____/____/_____ Sex: ❑ M ❑ F

Address _____ City/State/Zip _____

Best phone # (____) _____ Other phone # (____) _____

Emergency Contact _____ Contact phone # (____) _____

Primary Language Spoken _____

❑ Submit photo copy ID (i.e., Driver's License, ID card) SS# _____

Community Surgery Day Eligibility Guidelines

In order to qualify, a patient must meet both of the following requirements: (☑ please check all that apply)

❑ **Not require ongoing care by surgeon for successful recovery (referring clinic maintains responsibility for care beyond surgery, after initial post-op.);**

❑ Not possess co-morbidities that increase the risk of hospitalization (see medical exclusion criteria page 2)

I have read the terms and conditions (see page 3) for receiving surgical services from Your best Pathway to Health. I understand terms and agree to comply.

Patient's Signature/Firma _____ **Date/Fecha**_____

Surgical Procedure Requested

General Surgery	Orthopedics	Gynecology
❑ Colonoscopy	❑ Carpel tunnel release	❑ Dilatation and curettage
❑ Upper endoscopy	❑ Ulnar nerve release at elbow	❑ uterine ablation (novasure)
❑ Excision of benign mass	❑ Trigger finger or thumb release	❑ LEEP (Pap and cervical biopsy results needed)
❑ Surgical treatment of pilonidal cyst	❑ Bunion surgery	❑ Cystoscopy
❑ Inguinal hernia repair*	❑ Distal clavicle excision	❑ Endometrial ablation (Novasure)
❑ Umbilical hernia repair*	❑ Arthroscopy: ❑ Shoulder ❑ Knee ❑ Ankle ❑ Wrist ❑Right ❑ Left*	❑ Diagnostic Hysteroscopy
❑ Excisional biopsy	❑ Joint injections	❑ Polypectomy
❑ Excision or fulguration for warts	**Colorectal Surgery**	❑ Excision of vaginal cysts
Urology	❑ Hemorrhoidectomy	❑ Excision of vulvar lesions
❑ Bilateral vasectomy	❑ Colonoscopy	❑ Marsupialization of Bartholin cysts
❑ Hydrocele repair*		❑ Implantable contraception
❑ Circumcision*	**Ophthalmology**	
❑ Cystoscopy	❑ Ophthalmologic procedure_____	
	❑ Cataract removal	

**Procedure may not be offered at event*

Patient Name _____ Date of birth ____/____/_____ Sex: ❑ M ❑ F

Clinic Care Coordinator: Please fill out completely
Fax this form and attach all relevant chart notes to (855) 846-7705
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Medical Exclusion Criteria

- Active drug or alcohol abuse
- Uncontrolled mental illness
- Uncontrolled hypertension or diabetes
- BMI > 40
- ASA 4 or 5
- Cardiac - MI, CABG, angioplasty within 6 months, history of ischemic cardiomyopathy or recent (1 year) stroke
- Cirrhotic
- *Preferable:*
  - *Not on Coumadin or Plavix (would need to be able to stop for surgery for up to two weeks prior to operative date; Aspirin should be held for 7 days.)*
  - *Ability to stop smoking in perioperative period*

Symptoms _____

Current Diagnosis _____

Surgical Procedure Requested _____

YES	NO	Medical History
❑	❑	Anesthesia / Sedation Problems
❑	❑	Bleeding Disorder
❑	❑	Cancer / site: _____ date _____
❑	❑	COPD
❑	❑	Diabetes / HbA1c(<10) _____ date _____
❑	❑	Heart Disease / Stroke date _____
❑	❑	Hypertension / BP ____/_____ date _____
❑	❑	Kidney Disease
❑	❑	Liver Disease
❑	❑	Lung Disease / smoker
❑	❑	Sleep Apnea / using respiratory device
❑	❑	Seizures / Brain Injury
	❑	Substance or Alcohol Abuse

YES	NO	Medical History
❑	❑	Family History of Cancer
❑	❑	Other medical condition_____
❑	❑	Pregnant or Breast-feeding
❑	❑	Pertinent labs attached / CBC, eye notes, diagnostic tests
_____		BMI (<39)

YES	NO	Physical Assessment (If "NO" describe)
❑	❑	Ambulatory (age appropriate)
❑	❑	Teeth intact (not loose)
❑	❑	Neurologic: Alert, age appropriate
❑	❑	Heart Rate Regular
❑	❑	Peripheral Pulses Strong & Equal
❑	❑	Lungs Clear Bilaterally

Comments: _____

❑ Include eye notes for all cataract referrals

List Any Previous Hospitalizations & Surgeries (for the past year)_____

_____

Current Medications _____Allergies _____

Primary Care Clinic Contact Information

Referral Date _____/_____/_____ Physician's Signature _____

Phone (____) _____ Fax (____) _____

Referring Physician _____ E-mail _____

Clinic Contact/Case Manager _____ E-mail _____

Consent to Treatment by Volunteer Medical Professionals

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I understand that services I receive from Your best Pathway to Health, a service of Adventist Laymen's Services and Industries, and/or the facility where the procedure is performed, as affiliated with the Pacific Union Conference, the North American Division and General Conference of Seventh-day Adventists and Adventist Health/Adventist Health Systems, may be provided by a volunteer medical professional that is providing care that is not administered for or in expectation of compensation.
I further understand that state and federal law imposes a limitation on the recovery of damages from such a volunteer, or their affiliated volunteer organization, in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1. The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;
2. The volunteer commits the act or omission in the course of providing health care services to the patient;
3. The services provided are within the scope of the license of the volunteer; and before the volunteer provides health care services, the patient (or if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient) signs a written statement that acknowledges;
    a. That the volunteer is providing care that is not administered for or in expectation of compensation; and
    b. The limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

I HAVE READ AND UNDERSTAND THE ABOVE AND CHOOSE TO BE TREATED BY A VOLUNTEER MEDICAL PROFESSIONAL, UNDERSTANDING THE LIMITATIONS ON THE RECOVERY OF DAMAGES DESCRIBED ABOVE FOR:

❑ **Myself**

❑ **The following person for whom I am legally responsable (Print Patient Name):**_____

Name of Responsible party (if not Patient):_____

Signature of Patient/Responsible party_____
Date:_____

Consentimiento Para Recibir Tratamiento Por Un Profesional Médico Voluntario

Entiendo que los servicios que yo reciba en Your best Pathway to Health, un servicio de Adventist Laymen's Services and Industries, y Central Texas Medical Center, como afiliado a la Unión del Pacífico, División de América del Norte y la Conferencia General de Iglesia Adventista del Séptimo Día y Adventist Health/Adventist Health Systems, pueden ser administrados por profesionales médicos voluntarios los cuales están proveyendo este servicio sin esperar compensación monetaria.
Además entiendo que la ley de Texas impone limitaciones en las compensaciones que se puedan recibir a causa de danos causados por los servicios de un voluntario, o su organización de voluntarios afiliada, a cambio de haber recibido servicio medico. Estas limitaciones incluyen inmunidad de demandas civiles por cualquier acción a omisión que resulte la muerte, daños o heridas a algún paciente si:

1. El voluntario estaba actuando de Buena fe y sus acciones estaban dentro de sus funciones dentro la organización.
2. El voluntario comete la acción o comisión en el curso de proveer servicios médicos al paciente.
3. Los servicios administrados por el voluntario están dentro de las capacidades y licencias de mismo; y antes de recibir servicios del voluntario, el paciente, o si el paciente es un menor o por cualquier otra razón incompetente legalmente, el padre/madre de dicho paciente, o la persona que sea legalmente responsable del mismo firmara un documento por escrito que dice:
    A. Que el voluntario esta proveyendo servicios sin el propósito de recibir compensación y
    B. Las limitaciones en las compensaciones que se pueden recibir a cambio de haber recibido servicios médicos.

HE LEIDO Y ENTIENDO ESTE DOCUMENTO Y ACEPTO SER TRATADO POR UN VOLUNTARIO, Y ENTIENDO QUE HAY LIMITACIONES EN LAS COMPENSACIONES QUE SE PUEDAN RECIBIR POR DAÑOS YA DESCRITOS EN ESTA FORMA.

❑ **Yo**

❑ **Persona por la cual soy legalmente responsable (Nombre (Letra de molde)):** _____
Nombre de la parte responsable (si no Paciente):_____

_____ _____
Firma Del Paciente / Responsable Legal **Fecha**

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