



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

\*Procedure may not be offered at event

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### Medical Exclusion Criteria

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Active drug or alcohol abuse</li> <li>• Uncontrolled mental illness</li> <li>• Uncontrolled hypertension or diabetes</li> <li>• BMI &gt; 40</li> <li>• ASA 4 or 5</li> </ul> | <ul style="list-style-type: none"> <li>• Cardiac - MI, CABG, angioplasty within 6 months, history of ischemic cardiomyopathy or recent (1 year) stroke</li> <li>• Cirrhotic</li> <li>• <i>Preferable:</i> <ul style="list-style-type: none"> <li>○ <i>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.)</i></li> <li>○ <i>Ability to stop smoking in perioperative period</i></li> </ul> </li> </ul> |
|---|--|

Symptoms \_\_\_\_\_

Current Diagnosis \_\_\_\_\_

**Surgical Procedure Requested** \_\_\_\_\_

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

- | YES                      | NO                       | Medical History   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Family History of Cancer  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other medical condition _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant or Breast-feeding  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pertinent labs attached / CBC, eye notes, diagnostic tests<br>_____ BMI (<39) |

#### YES NO Physical Assessment (If "NO" describe)

- |                          |                          |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ambulatory (age appropriate)       |
| <input type="checkbox"/> | <input type="checkbox"/> | Teeth intact (not loose)           |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurologic: Alert, age appropriate |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Rate Regular                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Pulses Strong & Equal   |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

Clinic Care Coordinator: Please fill out completely

Revised 11/30/17

Fax this form and attach all relevant chart notes to (855) 846-7705

For more information, and for updates about the event, patients may visit [www.PathwayToHealth.org](http://www.PathwayToHealth.org) or call (888)444-PATHWAY



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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 responsible (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**