_____

Patient Name

Is scheduled for same day surgery on

_____

Day & Date

At _____AM/PM

Time

BARRANCA SURGERY CENTER

an affiliate of SCA

3500 Barranca Parkway
Suite 130
Irvine, Ca 92606
Phone: (949) 552-6266
Fax: (949)552-5038

Directions to Barranca Surgery Center

The entrance to Barranca Surgery Center is in the Main Lobby of the building. Our entrance is located on Barranca Pkwy. Our entrance is clearly marked with BARRANCA SURGERY CENTER, Suite 130 on our entry door. There are two entrances to the main lobby, they are shown in the image below. You can access our center from either entrance.

3500 Barranca Pkwy ● Suite 130 ● Irvine, Ca 92606
Ph: (949)552-6266 ● Fx: (949) 552-5038

Please do not hesitate to call our team if you need help navigating to our center.

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Dear Patient,

We are looking forward to your upcoming visit to Barranca Surgery Center. To facilitate the admitting process, we ask that you complete our online pre-admission registration with One Medical Passport. Attached to this sheet you will find a Patient Registration guide that will help you get started.

Forms to complete (fill out at home) and bring with you:

- Patient Attestation – ASC Conditions for Coverage (this is the leaflet in your facility brochure)

Bring Insurance Card(s) and Photo ID
Payment is accepted by Cash, Check or Credit Card (Visa, MC, Amex, Care Credit)

Before your procedure:

- Do not eat or drink anything ***8 hours*** prior to your schedule procedure time, unless otherwise instructed by your doctor.
- Take your usual medications with only a sip of water on the day of your procedure, unless otherwise instructed by your doctor.
- Wear comfortable clothes. Do not wear makeup (if having eye surgery), perfume or jewelry.

After your procedure:

- Our team of nurses will ensure a nurturing and comforting environment during the recovery period after your procedure.
- Our team is trained to address and manage any discomfort in the postoperative period
- You will be given written instructions and any necessary prescriptions before you leave.
- You must arrange to have a responsible adult drive you home from the surgery center.

At Home:

- If you experience any significant discomfort from nausea, bleeding, etc; you may contact your doctor through their office.

For further questions, please contact Barranca Surgery Center.

We look forward to providing you with Excellent Care & a Great Experience.
THE BARRANCA TEAM!

Patient Registration Guide

BARRANCA SURGERY CENTER
an affiliate of SCA

Physician: _____ Procedure Date: _____

Barranca Surgery Center asks that you complete online registration with One Medical Passport. The website will guide you to enter your medical history online so our staff can review your information well in advance of your procedure. This procedure will minimize long phone interviews and paperwork and help us to provide the best care possible for you.

Begin Registration:

Start by going to www.onemedicalpassport.com and click **Register** to create an account.

Additional Help to Complete Registration

If you are unable to complete online pre-admission, please call 714-744-0900 during business hours one week before or as soon as you are scheduled.

Create Your One Medical Passport Account

First time users of onemedicalpassport.com should click the green **Register** button and create an account. Answer the questions on each page , then click save and continue. Once complete, you will be prompted to click **Finish** to securely submit your information to us.

First Time Users Click Register

Username you chose: _____

Returning Users (for changes or reuse)

Enter the username and password you chose.
You can then access or update your account.

Barranca Surgery Center

Is this visit related to: (please check all appropriate boxes)

☐ Work Injury ☐ Auto Accident ☐ 3rd Party Liability ☐ None of the proceeding SSN # - -

PATIENT INFORMATION / DEMOGRAPHICS

First Name: MI: Last Name:

Date of Birth: Age: Hm phone: Cell phone:

Address: City: Zip:

Email Address: Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMPLOYER INFORMATION

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired

Occupation:

Employer Name: Telephone: Ext:

Address: City: Zip:

INSURED / RESPONSBLE PARTY INFORMATION

Primary Ins: ID #: Grp #:

Address: City: Zip:

Name of Insured: Relationship to Pt: Tel # DOB: / /

Secondary Ins: ID #: Grp #:

Address: City: Zip:

Name of Insured: Relationship to Pt: Tel #

EMERGENCY CONTACT INFORMATION

Name: Relationship to Pt:

Tel #:

THE INFORMATION ABOVE IS TRUE AND CORRECT

Signature: Date:

Barranca Surgery Center
3500 Barranca Pkwy, Suite 130 • Irvine, CA 92606
949 552-6266 • Fax 949 552-5038

ANESTHESIA QUESTIONNAIRE

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

SURGERIES AND ILLNESSES

HEIGHT: _____ WEIGHT: _____

Do you have any **MEDICATION ALLERGIES?** Yes No
If yes please list: _____

Do you have any **FOOD ALLERGIES?** Yes No
If "YES" please list: _____

Do you have **SLEEP APNEA?** Yes No
Are you allergic to **LATEX** or **RUBBER PRODUCTS?** Yes No
List any other hospitalizations with reasons and approximate dates and any chronic illness(es) or condition(s): _____

HAVE YOU EVER HAD:	YES	NO	If yes please explain
1. High Blood Pressure			
2. Heart Trouble or Heart Attack			
a) Chest pain or Angina			
b) Irregular Heart Beat			
c) Congestive Heart Failure			
d) Abnormal electrocardiogram			
3. Gastric Esophageal Reflux, Hiatal Hernia, Ulcers			
4. A recent cold, cough or sore throat			
5. Asthma, Emphysema, bronchitis or breathing problems			
6. Abnormal chest x-ray			
7. Diabetes			
8. Yellow jaundice or hepatitis			
9. Kidney Disease			
10. Abnormal bleeding problems			
11. Stroke, numbness or weakness			
12. Epilepsy or convulsive seizures			
13. Broken bones of back, neck or face			
14. Back trouble			
15. Unusual muscle problems or diseases			
16. Unexplained fevers or heatstrokes			
17. Bad reactions to anesthetics			
18. Any relative with bad reaction to anesthetics			
19. Psychological or emotional problems			
20. Any problems with motion sickness			
DO YOU:			
1. Wear dentures			
2. Have caps / dental veneers on teeth			
3. Drink alcohol (How much per day)			
4. Smoke (How much per day)			
5. Exercise or have strenuous activity			
6. Have physical limitations			
Female (If applicable) are you pregnant			
Are you aware there is a risk with **EVERY** Anesthetic given			
Do you have questions or concerns you would like to discuss with your Anesthesiologist?			

"I attest that the above information is true and correct to the best of my knowledge."

Signed by Patient, Parent or Guardian _____ Date _____

Questionnaire and Pre-Op teaching done by _____ Date _____

Patients Name _____

Barranca Surgery Center
949 552-6266 · Fax 949 552-5038

PATIENT RECONCILIATION MEDICATION LIST

Home Medication List is as provided by Patient
(Including prescriptions, over the counter, herbals, vitamins and birth control pills or patch.)

ALLERGIES: _____

Last dose Date Time	Medication History/Reconciliation Medication Name Dose/Route/Frequency/Comments	After Surgery Continue all medication unless otherwise indicated. Contact Physician with any questions.

FACILITY USE ONLY

Steroid Injection given in operating room ☐

Allergy/Medication List Reviewed and Verified with ☐ Patient ☐ Other_____ on day of service as current and complete: _____ (Nurse signature)

Additional Home Medications for Patient Discharge

Medication Name	Dose/Route/Frequency/Comments	Last Dose	Rx Given?

Additional Information: _____

☐Reviewed with patient _____ (Nurse signature)

☐A copy of this form provided to the patient upon discharge for educational purposees only

BARRANCA SURGERY CENTEI

HISTORY AND PHYSICAL

PATIENT NAME: **DOB:** **AGE:** **DOS:**

HISTORY

CHIEF COMPLAINT_____

_____

ALLERGIES: ◻ None

List: _____

_____

Reaction: _____

Latex Allergy: ◻ Yes ◻ No

MEDICATIONS/DOSE_____

_____

_____

PAST MEDICAL HISTORY:

◻ Yes ◻ No Bleeding Tendencies
◻ Yes ◻ No Brain, Nerve, Muscle Disease
◻ Yes ◻ No Cancer
◻ Yes ◻ No Diabetes
◻ Yes ◻ No Heart Disease
◻ Yes ◻ No Hypertension
◻ Yes ◻ No Liver Disease
◻ Yes ◻ No Lung Disease
◻ Yes ◻ No Infectious Diseases
◻ Yes ◻ No Sleep Apnea
◻ Yes ◻ No Other _____

SYSTEMS REVIEW: Please list problems with:

Cardio-Resp: Yes ◻ No ◻_____
Endocrine: Yes ◻ No ◻_____
GU/GI: Yes ◻ No ◻_____
Neuro: Yes ◻ No ◻_____
Vascular: Yes ◻ No ◻_____

Past Surgical History: _____

_____

_____

Family History: ◻ Cancer ◻ Cardiovascular
◻ Diabetes ◻ Anesthesia Problems
◻ Non-Contributory

Other:_____

_____

Social History: ◻ Single ◻ Married ◻ Divorced
◻ Widowed ◻ Separated

Smoking_____ Alcohol_____

Drugs_____Exercise_____

PATIENT LABEL

VITALS: B/P_____ P_____ R_____ T_____

PHYSICAL EXAMINATION: Ht:_____Wt:_____

◻ Alert ◻ Oriented ◻ Other:_____

HEENT:	◻ Normal	◻ Abnormal	
HEART:	◻ Normal	◻ Abnormal	
LUNG:	◻ Normal	◻ Abnormal	
BREASTS:	◻ Normal	◻ Abnormal	◻ Deferred
ABDOMEN:	◻ Normal	◻ Abnormal	
PELVIC:	◻ Normal	◻ Abnormal	◻ Deferred
RECTAL:	◻ Normal	◻ Abnormal	◻ Deferred
EXTREMETIES:	◻ Normal	◻ Abnormal	

Explanation of Abnormal(s)listed above:

_____

_____

_____

_____

_____

Pre-Op Diagnosis: _____

_____

_____

_____

Consent to Read: _____

_____

_____

_____

I have determined that this patient is a suitable candidate for the planned procedure at this facility. I have reviewed the patient's vital signs and all diagnostic test results and will follow up as appropriate. The patient/guardian accepts the proposed procedural/surgical plan.

Physician Signature _____

Date _____ **Time** _____

H & P/Interval Note: <u>24hr Update Day of Surgery</u>

Since the date of the patient's original evaluation, there have been no changes in the patient's pre-op diagnosis, chief complaint and procedure to be performed today. I have reviewed the patient's vital signs and all diagnostic test results and will follow up as appropriate. This patient is an appropriate candidate for outpatient surgery.

Physician Signature _____

Date _____ **Time** _____