Patient Name

Is scheduled for same day surgery on

_____

Day & Date

At _____AM/PM

Time

LA VETA SURGICAL CENTER

an affiliate of SCA

681 S Parker St.
Suite 150
Orange, CA 92868
Phone: (714) 744-0900
Fax: (714) 744-9232

Directions to La Veta Surgical Center

The entrance to La Veta Surgical Center is in the Main Lobby of the building. We are located in Building 681 of the Orange Financial Plaza Complex. Our entrance is clearly marked with La Veta Surgical Center, Suite 150 on our entry door.

681 S. Parker St. ● Suite 150 ● Orange, Ca 92868
Ph: (714)744-0900 ● Fx: (714) 744-9232

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

LA VETA SURGICAL CENTER

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681 S. Parker St ● Suite 150 ● Orange, Ca 92868
Ph: (714)744-0900 ● Fx: (714) 744-0283

Dear Patient,

We are looking forward to your upcoming visit to La Veta Surgical Center. To facilitate the admitting process, we are supplying you with some forms for you to complete. Please ***BRING THESE FORMS TO THE CENTER*** the day of your procedure.

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

- Medication Reconciliation form and Anesthesia Questionnaire.
- 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 La Veta Surgical Center.

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

Id:
Dob: Age: Sex:
Dos:

La Veta Surgical Center

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Medication Reconciliation List

Home medication list as provided by the Patient or Caregiver, includes all prescription, over the counter, herbal medications and recreational drugs.

Allergies:_____

_____

Medication Name	Dose	Route	Times per Day	Date & Time of Last Dose	Notes

This list has been reviewed and verified with the Patient or Caregiver and is current and complete as of this date. _____ **RN Date:** _____ **Time:** _____

Facility use only: Steroid injection given in OR Y N/A

✓ **After surgery continue to take all medications *unless otherwise instructed by your Physician.***

Additional Medications prescribed for Home use following your procedure

Medication Name	Dose	Route	Times per Day	Disposition of Prescription
				Pharmacy / Patient
				Pharmacy / Patient
				Pharmacy / Patient

Reviewed with Patient or Caregiver by _____ **RN Date:** _____ **Time:** _____

This form is for educational purposes and may be used as a communication tool for other Healthcare Providers. A copy has been provided to the patient.

La Veta Surgical Center

714 744-0900 • Fax 714 744-0283

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 _____

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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 Adress: 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:

La Veta 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: **24hr Update Day of Surgery**

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** _____