Suncoast Surgery Institute

PATIENTS RIGHTS AND RESPONSIBILITIES

ADVANCED DIRECTIVE POLILCY

NOTIFICATION OF PHYSICIAN OWNERS

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Suncoast Eye Center, Eye Surgery Institute

14003 Lakeshore Blvd.

Hudson, FL 34667

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We are required to provide you with the

following information both written and verbally

PRIOR to the date of your procedure.

____________________________________ _________________________

Signature of Patient or Legal Representative Date

Suncoast Eye Center | Eye Surgery Institute

Name: ______________________ Date of Birth: ______________ Age: __________

Procedure: ______________________ BP: _____ HR: _____ RR: _____ T: _____ Height: _____ Weight: _____

HAVE YOU HAD OR STILL HAVE:	Yes	No	COMMENTS:		Yes	No	COMMENTS:
* RESPIRATORY				* CARDIAC			
Emphysema / COPD				Coronary Artery Disease			
Do you use oxygen at home? Continuous _______ Only at night _______				Myocardial Infarction			
				Chest Pain / Angina *How Often* ___________			
Asthma				Arrhythmia			
Chronic Cough				Pacemaker *When Installed:* ________ *How Often Checked:* ________			
Shortness of Breath				Hypertension			
Sleep Apnea				Circulatory Problems			
CPAP				* NEURO			
Tuberculosis				Stroke			
Other: ____________________				Seizures			
Can you lie flat?				Other: ____________________			
Do you smoke				* HEPATITIS *Which Type* ___________			
Have you ever smoked							
Packs per day ___________				HIV			
How many years ___________				LIVER DISEASE			
Date quit ___________				THYROID PROBLEMS			
* ARTHRITIS				* KIDNEY PROBLEMS			
Rheumatoid ___________ *Osteo* ___________				*Renal Failure* ___________ *Stage 2* ____ *3* ____ *4* ____ *End Stage* ___________ *Dialysis Schedule* ___________ *Where is Shunt* ___________			
BACK PROBLEMS							
* CANCER				* BLOOD THINNERS			
Remission ___________ *Being Treated* ___________				*Coumadin / Warfarin* ____ *Aspirin* ____ *Other* ___________			
PROSTATE PROBLEMS				* DIABETES *Diet Controlled* ____ *Oral Medication* ____ *Insulin* ____ *Insulin Pump* ____ (Since NPO, need to turn pump off the morning of surgery, unless other directions from their physician)			
UNUSUAL REACTION TO ANESTHESIA IN THE PAST				* OTHER			
COLD / FLU IN PAST 2 WEEKS							

HISTORY & PHYSICAL

PRE-OP EVALUATION
Revised 12/2020

DRUG ALLERGIES: ______________________________

____

____

PRESENT MEDICATION AND STRENGTH:	**RESUME MEDICATIONS:**

HISTORY & PHYSICAL FORM

Hospitalizations the past 6 months – Why? ______________________________

____

____

Previous Major Surgeries and Year: ______________________________

____

Do you have a Health Care Surrogate? (If yes, please list) ______________________

____

Do you have an Advance Directives? (If yes, please provide a copy for your chart) ______________

____

I have read and understand the questionnaire and certify that the answers by me are correct to the best of my knowledge.

Patient Signature: ______________________________ **Phone:** ______________

Interviewer: ______________________________ **Date:** ______________

Reviewed by: ______________________ **R.N.** ______ **Date:** ______________

Doctor Signature: ______________________________ **M.D.** **Date:** ______________

****************** TO BE COMPLETED BY ANESTHESIA ******************

REVIEW OF SYSTEMS:

HEENT: ______________________ **LUNGS:** ______________________

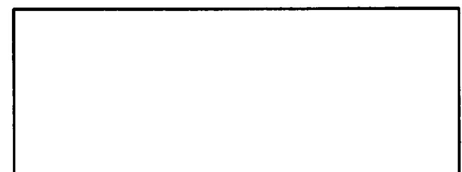
HEART: ______________________ **OTHER:** ______________________

ANESTHESIA PRE-OP NOTE: ______________________________

Risk and Procedure reviewed with patient: **Yes** ______ **No** ______

ANESTHESIA POST-OP NOTE: ______________________________

Anesthesia Signature: ______________________________ **Date:** ______________



NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES and

Acknowledgement of Patient Rights/Responsibilities,
Acknowledgement of Disclosure of Ownership Interest and
Acknowledgement of Notice of Privacy Practices.

Suncoast Eye Center requires the following notice be signed by each patient prior to scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and Florida laws and rules regarding advance directives. Advance directives are statements that indicated the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury.
There are many types of advance directives, but the two most common forms are:

Living Wills:
These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.

Durable Power of Attorney for Health Care:
This is a signed, dated and witnesses paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient. If you disagree, you must address this issue with your physician or anesthetist prior to signing this form.

☐ **I have read and fully understand the information in this release form**

- ☐ I **DO NOT** have a Living Will or durable Power of Attorney for Health Care (See FloridaHealthFinder.gov for information)
- ☐ I **DO** have a Living Will or durable Power of Attorney for Health Care
    - ☐ Has been provided to the facility
    - ☐ Has NOT been provided to the facility
- ☐ **I have been given the opportunity to receive a copy of the patient Rights and Responsibilities for this Facility**
- ☐ **I have been given the opportunity to receive a copy of the Disclosure of Ownership Interest for this facility**
- ☐ **I hereby acknowledge that I have been given the opportunity to receive a copy of the Notice of Privacy Practices for this facility.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the appropriate person as outlined in the complaint section of the Notice of Privacy Practices.

I have read and fully understand the information presented in this release form.

_______________________	_______________________
Patient's Signature	Date and Time
_______________________	_______________________
Legal Guardian's Signature	Relationship to Patient

10/2020