David F Plotsky, MD, PC
Pediatric Ophthalmology & Adult Strabismus
6410 Rockledge Drive, Suite 108
Bethesda, Maryland 20817
301-530-6699
www.docplot.com info@docplot.com

Surgical Information - Patient Responsibility

Please review the following information carefully. All steps must be completed before your surgery.

Contact our office if you have any questions (301) 530-6699

Patient name: _____
Surgery Date: _____
Facility:_____

Patient Pre-Operative Instructions –

1. It is your responsibility to schedule an appointment to have your pre-operative evaluation with your primary care physician. Please bring the required History and Physical form to your appointment. This form can be found at www.docplot.com/download.htm. Scroll down the page and locate name of the hospital where your procedure is scheduled, then click the History & Physical link. Please have the results faxed to (301) 581-0969 at least 4 days prior to surgery. **Failure to complete this form may result in cancellation of surgery**.

____ History and Physical
____ EKG (required for men over 40 and women over 50)
_____LABS – only if PCP requires for surgical clearance

If taking daily medication, check with your prescribing doctor concerning their use on day of surgery and notify Dr. Plotsky.

2. Arrange for a ride home: You will not be released without an adult to accompany you

3. On the evening before surgery you may not eat or drink anything after midnight unless instructed by the facility to do otherwise

*Our office will obtain all precertifications and referrals for your surgery

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Patient Check-In Instructions

Check-in time: _____
Place: _____

The surgery center - not our office - will confirm check in time at the facility.

You will be notified of your check-in time by the nurse at the hospital a few days prior to your surgical date. All surgery times are approximate.

Suburban Outpatient Surgery Center …… 301-896-6700
Children's Ambulatory Surgery Center …… 301-424-1755
Washington Hospital Center ……. 202-877-7000
Georgetown University Hospital ……..... 202-444-2000

You may anticipate staying at the surgery center about 2 hours after the surgery begins.

Patient Post-Operative Instructions

Eye Muscle Surgery: Use antibiotic ointment twice a day in operated eye. Use cool compresses for 48 hours. Make an appointment to see Dr. Plotsky within 1 week.

Tearduct Surgery: Use eyedrops twice a day for 5 days. Make post-op appointment 2-3 weeks following surgery.

Chalazion Excision: Use Tobradex ointment twice a day for 1 week. Use warm compresses twice a day. Make post-op appointment 3 weeks following surgery.

OTHER:

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ATTENTION!!!

You must take this form with you to your pre-operative physical.

It is your responsibility to take this form with you to your appointment. Failure to take this form to your appointment may result in a rescheduling of your appointment and/or surgery.

Your doctor's office should fax the completed form to:

301-581-0969

In addition, please obtain a copy of the completed form and take it with you to your surgery. This will ensure that you are cleared for your operation.

Check with your insurance company for participating clinics.

Diagnosis code: _____

Procedure code: _____

WASHINGTON HOSPITAL CENTER

NAME _____ / / /
(Last) (First) (Middle Initial) Date of Birt

Proposed Procedure (Surgery) _____

Reason for Procedure _____

Patient, Nurse or House Officer to Complete

When did you last eat or drink? _____ Have you had problems with local or general anesthesia? Yes ____ No

Explain _____

Allergies (Cause & type of reaction) _____

Medicines (Name & dose) _____

_____

PAST OR SYSTEMIC ILLNESS (Check & circle all that apply)

BRAIN	_____	Seizures, stroke, paralysis, mental illness
EYES	_____	Cataract, difficult vision, other
GLANDS	_____	Diabetes, thyroid, adrenal, ovary
GYN	_____	Pregnant now, last normal menses _____
HEAD	_____	Loose teeth, dentures, swallowing problems
HEART	_____	High blood pressure, chest pain, irregular heart
INTESTINE	_____	Vomiting, cramps, diarrhea, blood
KIDNEY	_____	Infection, failure, stones, dialysis
LIVER	_____	Hepatitis, jaundice
LUNG	_____	Smoking, recent cold, asthma, emphysema
TUMOR	_____	Where? _____
OTHER	_____	_____

Attending/Anesthesia Comments _____

_____

_____

PERTINENT PHYSICAL FINDINGS BP / H _____, Wgt _____

Oriented x3 _____ Y _____ N Visual acuity (if applicable)

Heart Lungs

Regional findings related to procedure

_____ _____ _____
Attending Signature Title Date

SHORT STAY HISTORY AND PHYSICAL FORM

DATE

***EKG required for men over 40 and women over 50 years of age. Blood work and other tests for surgical clearance as required by PCP.**