Global Care Medical Center
100 Main St
Alfred NY 14802
(607) 555-1234

Ambulatory Surgery Face Sheet

Patient Information:

Name:	SNOW, Chrissy	Patient Number:	ASUCase010
Address:	5908 Jefferson Road	Date of Birth:	10-22-YYYY
City:	Richfield Springs	Age:	39
State:	NY	Gender:	Female
Zip Code:	13468	Organ Donor:	N
Telephone:	555-555-5554	Date of Admission:	07-23-YYYY

Admitting Information:

Surgeon:	Rusty Gates, M.D.	Service:	Orthopedics
Primary Care Provider:	Charlie Hoffmann, M.D.	Financial Class:	Blue Cross (BC)

Codes

Admitting Diagnosis: Left middle trigger finger

First-Listed Diagnosis: Left middle trigger finger

Secondary Diagnoses:

First-Listed Procedure: Incision of tendon sheath, left middle trigger finger

Secondary Procedures:

Surgeon's Signature Reviewed and Approved: Rusty Gates MD ATP-B-S:02:1001261385: Rusty Gates MD (Signed: 7/23/YYYY 2:20:44 PM EST)

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Consent for Operation(s) and/or Procedure(s) and Anesthesia

PERMISSION. I hereby authorize Dr. Rusty Gates, M.D. , or associates of his/her choice at the Global Care Medical Center (the "Hospital") to perform upon Chrissy Snow the following operation(s) and/or procedure(s): Tenolysis

including such photography, videotaping, televising or other observation of the operation(s)/procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that the patient's identity will remain anonymous.

EXPLANATION OF PROCEDURE, RISKS, BENEFITS, ALTERNATIVES. Dr. Rusty Gates, M.D. has fully explained to me the nature and purposes of the operation(s)/procedures named above and has also informed me of expected benefits and complications, attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

UNFORESEEN CONDITIONS. I understand that during the course of the operation(s) or procedure(s), unforeseen conditions may arise which necessitate procedures in addition to or different from those contemplated. I, therefore, consent to the performance of additional operations and procedures which the above-named physician or his/her associates or assistants may consider necessary.

ANESTHESIA. I further consent to the administration of such anesthesia as may be considered necessary by the above-named physician or his/her associates or assistants. I recognize that there are always risks to life and health associated with anesthesia. Such risks have been fully explained to me and I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

SPECIMENS. Any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with accustomed practice and applicable State laws and/or regulations.

NO GUARANTEES. I acknowledge that no guarantees or assurances have been made to me concerning the operation(s) or procedure(s) described above.

MEDICAL DEVICE TRACKING. I hereby authorize the release of my Social Security number to the manufacturer of the medical device(s) I receive, if applicable, in accordance with federal law and regulations which may be used to help locate me if a need arises with regard to this medical device. I release The Global Care Medical Center from any liability that might result from the release of this information.*

UNDERSTANDING OF THIS FORM. I confirm that I have read this form, fully understand its contents, and that all blank spaces above have been completed prior to my signing. I have crossed out any paragraphs above that do not pertain to me.

Patient/Relative/Guardian* Chrissy Snow (Signature) | Chrissy Snow (Print Name)

Relationship, if other than patient signed:

Witness: (Signature) | (Print Name)

Date: 07-23-YYYY

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

PHYSICIAN'S CERTIFICATION. I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to the operation(s)/ procedure(s), have offered to answer any questions and have fully answered all such questions. I believe that the patient (relative/guardian) fully understands what I have explained and answered.

PHYSICIAN: Reviewed and Approved: Rusty Gates MD ATP-B-S:02:1001261385: Rusty Gates MD (Signed: 7/23/YYYY 2:20:44 PM EST)

Signature

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Ambulatory Surgery Operative Report

PATIENT INFORMATION:

NAME:	SNOW, Chrissy	PATIENT NUMBER:	ASUCase010
DATE OF SURGERY:	7-23-YYYY		
SURGEON:	Rusty Gates, M.D.	ASSISTANT SURGEON:	None

PREOPERATIVE DIAGNOSIS: Left middle trigger finger.

POSTOPERATIVE DIAGNOSIS: Left middle trigger finger.

PROCEDURES: Incision of tendon sheath, left middle trigger finger.

DESCRIPTION OF PROCEDURE:

Under satisfactory IV block anesthesia, the patient was prepped and draped in the usual fashion. A transverse incision was made parallel to the distal palmar crease overlying the middle finger and the wound was then deepened by sharp dissection and blunt dissection being very careful to preserve all blood vessels intact and not to disturb the neurovascular bundle. The flexor tendon sheath was identified and divided longitudinally for a distance of approximately 1/5 cm. There was no bow stringing of the flexor tendon following this and there was good gliding motion of the flexor tendon passively without any obstruction. The patient then had closure of the subcutaneous tissue with on interrupted 4-0 plain catgut suture, and the skin was approximated with 3 interrupted 4-0 nylon vertical mattress sutures. Betadine ointment and dry sterile dressing was applied. Bulky hand dressing was applied. The patient, having tolerated the procedure well, had the tourniquet released without any untoward effects and was returned to ASU in satisfactory condition.

SURGEON'S SIGNATURE

Reviewed and Approved: Rusty Gates MD ATP-B-S:02:1001261385: Rusty Gates MD (Signed: 7/23/YYYY 2:20:44 PM EST)

Rusty Gates, M.D.

RG: ygc
DD: 07-23-YYYY
DT: 07-23-YYYY

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AMBULATORY SURGERY LABORATORY DATA

PATIENT NAME:	SNOW, Chrissy	**PATIENT NUMBER:**	ASUCase010
LOCATION:	ASU	**ASU PHYSICIAN:**	Rusty Gates, M.D.
DATE:	07-26-YYYY	**SPECIMEN:**	Blood

Test	Result	Flag	Reference
Glucose	105		**82-115 mg/dl**
BUN	15		**8-25 mg/dl**
Creatinine	1.0		**0.9-1.4 mg/dl**
Sodium	138		**135-145 mmol/L**
Potassium	3.7		**3.6-5.0 mmol/L**
Chloride	101		**99-110 mmol/L**
CO2	23		**21-31 mmol/L**
Calcium	8.8		**8.6-10.2 mg/dl**
WBC	9.9		**4.5-11.0 thous/UL**
RBC	4.5		**5.2-5.4 mill/UL**
HGB	11.9		**11.7-16.1 g/dl**
HCT	38		**35.0-47.0 %**
Platelets	175		**140-400 thous/UL**
PT	12.0		**11.0-13.0 seconds**

** END OF REPORT **