

**Global Care Medical Center**

100 Main St
Alfred NY 14802
(607) 555-1234

**Ambulatory Surgery
Face Sheet****PATIENT INFORMATION:**

NAME: SPRINGS, Hope
ADDRESS: 90 Washington Street
CITY: West Winfield
STATE: NY
ZIP CODE: 14500
TELEPHONE: 555-555-9999

PATIENT NUMBER: ASUCase009
DATE OF BIRTH: 09-23-YYYY
AGE: 3
GENDER: Female
ORGAN DONOR: N
DATE OF ADMISSION: 07-23-YYYY

ADMITTING INFORMATION:

SURGEON: Rusty Gates, M.D.
PRIMARY CARE PROVIDER: Fred Stryker, M.D.

SERVICE: Orthopedics
FINANCIAL CLASS: Blue Cross (BC)

CODES

ADMITTING DIAGNOSIS: Admission for removal of surgical hip screw (implant)

FIRST-LISTED DIAGNOSIS: Admission for removal of surgical hip screw (implant)

SECONDARY DIAGNOSES:

FIRST-LISTED PROCEDURE: Removal of hip screw (implant)

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, MD, or associates of his/her choice at the
Global Care Medical Center (the "Hospital") to perform upon Hope Springs
the following operation(s) and/or procedure(s): Removal hip screw (implant)

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, MD

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*

Hope SpringsHope Springs

Signature

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
Pathology Report****PATIENT INFORMATION:**

NAME: SPRINGS, Hope
DATE: 07-25-YYYY
PATHOLOGIST: Peter Frank, M.D.

PATIENT NUMBER: ASUCase009
DATE OF SURGERY: 07-23-YYYY
SURGEON: Rusty Gates, M.D.

CLINICAL DIAGNOSIS AND HISTORY:

S/P right hip osteotomy.

TISSUE(S) SUBMITTED:

Tissue and bone, right hip.

GROSS DESCRIPTION:

Specimen is received in fixative and consists of multiple irregular pieces of bone that are 3.5 x 2 x 1 cm. The largest dense cortical piece is 2.5 x 0.8 x 0.6 cm. Also present is an ellipse of dark gray-black skin, 8 x 0.6 cm. It has a slightly raised, longitudinal, wrinkled scar with dense tissue in the dermis.

MICROSCOPIC DESCRIPTION:

2 microscopic slides examined.

DIAGNOSIS:

Scar of skin, bone with intramedullary fibrosis and degenerated fibrocartilage, clinically right hip area.

PATHOLOGIST'S SIGNATURE: Reviewed and Approved: Peter Frank MD ATP-B-S:02:1001261385: Peter Frank MD (Signed: 7/23/YYYY 2:20:44 PM EST)

PF:ycg

Peter Frank, M.D.

DD: 07-25-YYYY

DT: 07-27-YYYY

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**AMBULATORY SURGERY
LABORATORY DATA**

PATIENT NAME:	SPRINGS, Hope	PATIENT NUMBER:	ASUCase009
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 **