OREgon
SURGERY CENTER
A division of Mercy Medical Center

2801 NW Mercy Drive, Suite 200
Roseburg, OR 97471
Telephone (541) 677-2800
Fax (541) 677-2820

YOU SHOULD ARRIVE AT THE OREGON SURGERY CENTER ON:

Day _____ Date _____ Time _____ .

Please do not be late

Dear Patient,

Please carefully review the enclosed information and complete the PATIENT HEALTH HISTORY page. This information is very important for your surgery/procedure. In addition, a pre-op nurse may call you to ensure your health history in our file is current.

PLEASE NOTE that it is ORegon Surgery Center's policy that the parents, guardians, and family of patients 18 years old and younger, 60 years old and older and disabled patients ARE REQUIRED to remain at the Surgery Center during the procedure.

PLEASE BRING THIS PACKET WITH YOU TO YOUR SURGERY/PROCEDURE. If possible, please drop off this packet at ORegon Surgery Center as soon as you complete these forms.

Pre-registration staff may call you a few days prior to your surgery to update your personal information and review your payment obligation with you.

If you have any questions about this packet, call ORegon Surgery Center's Pre-Op Clinic at (541) 677-2835. The hours vary for the Pre-Op Clinic, so if you reach their voice mail, please leave a detailed message and a nurse will return your call.

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Food or Drink: After midnight and until you have your surgery, you should have ***nothing at all by mouth unless*** you have been ***specifically instructed*** differently by your Surgeon or Anesthesiologist. This means no food, liquids, juice, coffee, tea, milk, or water. You may brush your teeth, but do not swallow any water.

Medications: ***Only take medication for your heart or blood pressure with one sip of water the morning of surgery. (If on insulin or diabetes pills – hold morning dose.)*** **DO NOT TAKE ANY OTHER MEDICATION** ON THE MORNING OF SURGERY UNLESS INSTRUCTED TO DO SO BY YOUR ANESTHESIOLOGIST OR SURGEON.

For your safety, any exception to the "Food or Drink and Medications" instructions above must be approved prior to surgery by your Anesthesiologist. Your procedure may be rescheduled or canceled if these instructions are not observed.

The Day of Your Surgery: To make your Surgery Center visit as easy as possible, there are several things you should do ahead of time:

- Arrange for someone to drive you home after surgery
- Arrange for someone to be with you the first night after surgery
- Bathe or shower in the morning and wear clean, comfortable clothing that will fit easily over bandages. For knee surgery no jeans, for eye surgery no long sleeve shirt or blouse.
- Remove all makeup prior to arrival
- Leave watches, jewelry (including wedding bands), metal body piercings, and credit cards or other valuables at home to avoid potential loss
- Bring a list of all your current prescription medications
- Bring all reports, X-rays, or papers given to you by your doctor
- If the patient is a child, do not forget to bring a favorite toy or blanket

Patients under the age of 18 should have a parent or legal guardian accompany them. The parent or legal guardian must sign the necessary forms and talk with the anesthesiologist. **If not the parent, the guardian must bring a copy of court authorization. We request that the parent or guardian remain at the Surgery Center during the surgery.**

- Bring your **insurance card and photo ID with you**.

If you are having foot, ankle, or knee surgery it is a good idea to bring crutches with you. You may purchase or rent them at most local pharmacies.

Most prescriptions you receive may be filled at your regular pharmacy.

Your Arrival: A parking lot is available across from ORegon Surgery Center. You may drop the patient off in front drive-thru then park in the parking lot across the street.

To ensure your safety, **we require that you arrange for a ride home before your surgery**. If no one can drive you, call MMC Express #464-5555 to make reservations. Reservations must be scheduled prior to the day of surgery. If you have not planned for transportation home, your **surgery will be postponed or canceled until you have arranged for a responsible adult to drive you home**.

Anesthesia: Your anesthesiologist or your doctor will review your chart and determine with you the type of anesthesia best for you. Five types of anesthesia are commonly used for outpatient surgery: general, regional, IV sedation, local, and topical.

- **General anesthesia** is usually administered by adding medications to your IV and having you breathe a mixture of anesthetic gases.
- **Regional anesthesia** is administered by injecting medication around the main nerves to the affected area. This will produce numbness lasting from 1 to 4 hours. You may also be sedated during your surgery.
- **IV sedation** is administered by adding sedatives and medication to IV to induce sleep. This will be at the direction of your doctor.
- **Local anesthesia** is administered by injecting medication just under the skin to numb a small area.
- **Topical anesthesia** is administered by applying medication to the mucous membrane for surgeries involving the nose, throat, or bladder.

Your heart rate, blood pressure, oxygen concentration, and breathing will be monitored with special equipment throughout your operation, regardless of the type of anesthesia administered.

After Your Surgery: From the PACU (Post-Anesthesia Care Unit), or recovery room, you will be taken to the Phase II recovery area. Due to space limitations, only one visitor at a time is allowed in the Phase II recovery area. Both parents may accompany a child who has had surgery.

You will be discharged from ORegon Surgery Center when you are stable, and it is appropriate to go home. Depending on the procedure or surgery you had, you will be ready to leave anywhere from 30 minutes to 4 hours later.

Your Care at Home: When you are discharged, you will be given **written instructions** for your care at home. Be sure to follow your doctor's orders. Take pain medications as prescribed by your doctor. Follow a liquid diet for the first 6 hours following surgery, then advance to your regular diet. Once home you will need plenty of rest. **Arrange to have a responsible adult stay with you through the night.** If you have any **problems related to surgery or your procedure, call your doctor.**

Your Care at Home following Endoscopy: Take pain or other medications as prescribed by your doctor. Eat a regular diet, just not large amounts at first.

It will feel good to recover in your own home, but remember not to do too much too soon!
For the first 24 hours following your surgery, regardless of how you feel,

- **DO NOT** drive a car or take public transportation by yourself
- **DO NOT** drink alcohol
- **DO NOT** sign legal documents or make important decisions
- **DO NOT** operate potentially dangerous equipment.

If you received local or topical anesthesia, you may return to normal activities without the 24 hour restrictions above. However, do follow the restrictions ordered by your doctor for your particular surgery.

You should receive a follow-up call from the Surgery Center nurse 1 to 2 days after your surgery. The Surgical Services nurse will be happy to answer any questions you may have about your postoperative care. In the mean time, call your doctor with any concerns or questions.

PATIENT HEALTH HISTORY

PHYSICIAN'S NAME _____ SURGERY DATE _____

EVALUATION:

1. Height _____ Weight _____
2. Activity Level: ☐ Low (Light Housework) ☐ Moderate (Walk Up a Hill) ☐ High (Strenuous Sports)

	YES	NO	SPECIFY
3. Is your physical activity ever limited due to shortness of breath or chest pain?	☐	☐	_____
4. Do you use Oxygen or a C-Pap machine at home?	☐	☐	_____
5. Have you or any member of your family ever had a bleeding disorder?	☐	☐	_____
6. Have you or any family member ever had a history of problems with anesthesia?	☐	☐	_____
7. Any allergies to medications or any unusual drug reactions?	☐	☐	

Please list _____

_____

8. Do you smoke or did you smoke? ☐ Yes ☐ No Packs/Day? _____ How many years? _____ Stopped _____
9. Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____
10. Do you use recreational drugs? ☐ Yes ☐ No What kind? _____
11. Do you have any significant illness or injury? _____
12. Do you take any medications regularly? ☐ Yes **PLEASE LIST ON MEDICATION SUMMARY FORM.** ☐ No
13. Have you taken any Aspirin, Ibuprofen, Coumadin, Plavix, or Aggrenox in the last two (2) weeks? ☐ Yes ☐ No

Have you now or have you ever had?	YES	NO	Have you now or have you ever had?	YES	NO
Bleeding tendency	☐	☐	Implantable devices/pacemaker/defibrillator	☐	☐
Blood clots in the legs	☐	☐	Liver disease	☐	☐
Cancer – list type _____	☐	☐	Hepatitis B or C, or MRSA bacterial infection, or HIV	☐	☐
Chest pain	☐	☐	Skin problems (cuts, rashes, open sores)	☐	☐
Heart disease/heart attacks/heart surgery	☐	☐	Stroke/dizziness/blackouts	☐	☐
Mitral valve prolapse	☐	☐	Seizures	☐	☐
High blood pressure	☐	☐	Thyroid disease	☐	☐
Emphysema	☐	☐	Motion sickness	☐	☐
Asthma	☐	☐	Facial fractures	☐	☐
Kidney disease	☐	☐	☐ Recent cold ☐ Infection	☐	☐
Hiatal hernia/heartburn	☐	☐	☐ Dentures ☐ Partials ☐ Crowns ☐ Caps	☐	☐
Diabetes	☐	☐	☐ Loose ☐ Broken ☐ Chipped teeth ☐ Jaw pain	☐	☐

Have you been hospitalized in the last year? ☐ Yes ☐ No If yes, why? _____

Previous Surgeries (When): _____

_____

Do you have an Advance Directive/Health Care Power of Attorney? ☐ Yes ☐ No Would you like information? _____

Do you have a DNR (Do Not Resuscitate) or a POLST (Physician Order Life Supporting Treatment)? ☐ Yes ☐ No

If yes, bring the DNR or POLST with you the day of surgery.

In the last year, have you been hit, slapped, or otherwise physically hurt by someone? ☐ Yes ☐ No

Do you ever fear for your safety or for the safety of your family members? ☐ Yes ☐ No

Would you like to talk to someone privately or get information about help/resources for domestic violence? ☐ Yes ☐ No

Females: Could you be pregnant? ☐ Yes ☐ No Date of last period _____ Hysterectomy? ☐ Yes ☐ No

Anesthesia in the 1st trimester can cause miscarriage. A pregnancy test will be performed if you are of childbearing age.

Patient's Signature _____ Date _____

8600338 (2/16)

CHI Mercy Health
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2700 Stewart Parkway Roseburg, OR 97471

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PATIENT LABEL

DT0234

MEDICATION SUMMARY

PLEASE INCLUDE ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICINES

Medication	Dose / Strength	How Often / Time Taken	Last Dose Taken

ALLERGIES / INTOLERANCES

Medication / Food	Reaction

8600343 (2/16)

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PATIENT LABEL

DT0234

GENERAL CONSENT TO HOSPITAL CARE

The undersigned patient or patient's authorized legal representative hereby consents to admission to Mercy Medical Center for diagnostic tests, procedures, care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of the testing procedures, care or treatment in the hospital. I consent to and authorize the following:

CLINIC

Medical Consent: I consent to hospitalization, diagnostic tests (including X-ray and laboratory), and other hospital procedures and therapy performed or prescribed by the attending physician, his designees or assistants, during this hospitalization. I consent to photographing and videotaping of operations or procedures, attendance of observers, disposal of any tissue or parts removed, all or any of which is deemed advisable by the doctor or assistant.

Blood Transfusion: I consent to the transfusion of blood and blood products as deemed necessary. (If refused, sign Refusal to Permit Blood Transfusion).

Advance Directive: I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. The hospital will provide me with information about Advance Directives.

RELEASE

Release of Confidential Information: I authorize Mercy Medical Center to release any information, including information from my medical record necessary to facilitate health care claims processing and payments. I understand that a separate authorization may be required for the release of my medical records containing specific information related to the testing, diagnosis and/or treatment of sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health/psychiatric disorders. I also consent to the release of any information as needed for post-discharge care or transfer of care to other health care facilities or agencies as I direct or as required by law. (If refused, please draw a line through and initial.)

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

Patient Portal: Mercy provides online access to your health information, including test results through a Patient Portal.

Patient Rights and Responsibilities: Your rights and responsibilities are respected at Mercy. Each department and every patient room has a copy of your rights and responsibilities for your reference.

FINANCIAL

Preauthorization: Many insurance carriers require preauthorization and/or second opinions. I understand that meeting these requirements is my responsibility.

Assignments of Benefits: In the event I am entitled to hospital benefits of any type whatsoever arising out of any insurance policy insuring me or any party liable to me, said benefits are hereby assigned directly to the hospital for application on my account. I understand I am financially responsible to the hospital for any charges not paid under this assignment and agree to pay such charges in accordance with the financial agreement signed by me on my behalf.

Financial Agreement: I agree to pay for any services rendered in connection with my stay at Mercy Medical Center. The balance of my bill is due 30 days from the first date of billing. If I am unable to pay, a payment plan may be established. If payment of the bill creates a financial hardship, I understand I may inquire about assistance by contacting a Mercy financial representative. The hospital reserves the right to require payment of insurance co-pays, deductibles and deposits in advance of hospitalization or at the time services are rendered. I understand I am responsible for any charges not covered by my insurance.

You will receive a separate bill for consulting physicians and other health care professionals who provide services to you as ordered by your doctor. The Radiology, Pathology and Anesthesiology charges on your statement are for materials and facilities. I acknowledge that the health care providers treating me may be independent contractors not employed by the hospital. I specifically acknowledge that any radiologists, anesthesiologists, pathologists and emergency room physicians involved in my care are independent contractors and not employees of the hospital.

NOTE

Personal Valuables: I acknowledge that the hospital maintains a safe for the safekeeping of money and valuables and shall not be liable for the loss or damage of any money, jewelry, documents or other small articles of value unless deposited for safekeeping. I understand that I am responsible for all valuables and personal belongings retained and taken to my room.

Communications Consent: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

YOUR OPINION MATTERS TO US

Mercy's priority is to ensure that you are provided safe, high-quality care and exceptional services. It is important that we receive feedback from our patients about how well we met their expectations in relation to their hospital stay or procedure. Please feel free to share your comments with any staff member who is providing care to you. We want our patients to know that we also use the services of a company(s) to assist us in gathering information through a survey. If you are randomly selected to participate, you will be contacted by the survey company. We will use the feedback we receive for quality assurance purposes and to improve our performance and service.

I acknowledge that this form has been fully explained to me and that I have read and understand its contents and the attached Notice of Patient's Rights. I also acknowledge receipt of a copy of these forms. I certify that as the patient, his/her representative or legal guardian, I accept the terms of this document.

Patient or Patient's Representative

Relationship

Do not sign at this time.
You will sign on the day of your surgery.

Witness

Date and Time

PACK 8600109 (2/16)

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PATIENT LABEL

DT0048

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Important Information

OREgon Surgery Center is designed to:

- Allow you to arrive, have surgery and go home the same day
- Give you efficient, personal care in a pleasant atmosphere
- Allow a family member to be present in recovery areas

OREgon Surgery Center charges do not cover the professional service fees of your surgeon or assistant surgeon.

It may be necessary, in connection with your surgery, to include or perform certain other services such as:

- X-Ray or EKG
- Examination of tissue removed
- Administration of anesthetics and medications

If the services are deemed necessary, OREgon Surgery Center charges do not cover the service fees of the:

- Anesthesiologist
- Radiologist
- Pathologist
- Physician Consultant

Also, any services not directly related or incidental to your surgery are not included in the Oregon Surgery Center fee.

Additional Instructions:

_____

_____

Please leave children at home as our patients need a quiet environment.

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Insurance & Billing

1. If your surgery is covered by insurance, please bring a current insurance, Medicare or Medicaid card to ORegon Surgery Center.
2. All charges are the patient's responsibility. As an added service to our patients, once coverage has been confirmed, we will bill the insurance company. Patient bills are due and payable within 30 days from date of billing. MasterCard and Visa are accepted.
3. The quoted fee is based on the scheduled procedure. In rare instances, unanticipated complications may cause the final fee to differ.
4. Cosmetic surgery fees are payable in full the day of surgery.

If you have any questions, please call ORegon Surgery Center at 541-677-2800.

Patient Rights

- To expect to be treated with respect, consideration and dignity.
- To be provided appropriate privacy.
- To expect that all disclosures and records are treated confidentially and released only with the patient's consent or when required by law.
- To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis.

Patient Responsibilities

- Accurately inform staff of correct billing address, phone number, age and social security number.
- Provide accurate information concerning health-related issues such as allergies, etc.
- Follow directions regarding medications and discharge instructions.
- Be on time for your scheduled appointment.
- Treat our staff with respect and decency.

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SURGERY INFORMATION

Having surgery and anesthesia affects other parts of your body in addition to the surgical site.

Medications may make your breathing slow and shallow, allowing normal fluids to collect. Inactivity also contributes to lung congestion as well as sluggish circulation and constipation.

The following exercises speed up recovery and help prevent pneumonia, blood clots, and other complications. You will be expected to do them several times each hour while awake.

DEEP BREATHING

Deep breathing helps rid your body of anesthesia gases and prevents fluid buildup in the lungs.

- Breathe in as deeply as you can
- Hold your breath for 5-10 counts
- Repeat 4-5 times every hour while awake and continue for several days after your surgery.

COUGHING

Coughing helps clear fluid from the lungs.

- If your surgery was on your abdomen or chest it may help to hold a pillow firmly over the incision for support. The sutures are strong and will not break from these coughing exercises.
- Breathe in deeply
- Cough deeply from the stomach area, not just clearing your throat
- Cough 2-3 times to loosen mucous and bring it up so you are able to spit it out
- Repeat 4-5 times every hour while awake and continue for several days after your surgery.

OUTPATIENT SURGERY – Planning for Discharge

- It is routine and expected that you go home the same day as your surgery
- You MUST arrange for transportation home following your surgery. We prefer for children to have 2 adults to accompany them home
- **Insurance companies will not pay for extended hospitalization due to transportation problems, lodging problems (no matter how far away you live), or insufficient help at home**
- If you choose to remain in the hospital for any of the above reasons after your doctor has given you permission to go home, you will be responsible for paying any additional expenses
- If it is medically necessary for you to stay beyond the usual recovery time, you will either remain in an Extended Recovery area or be transferred to a hospital room until you are stable for discharge. This can occur at any time up until midnight or even the next morning
- You will still be considered an “outpatient” even if you spend the night
- Your insurance company will handle the bill as usual as long as the stay is medically necessary.

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Our Location