LIGHTHOUSE ORTHOPEDICS

Comprehensive Musculoskeletal Centers

1821 N.E. 25th Street
Lighthouse Point, Florida 33064
(954) 942-0321 • Fax: (954) 946-7018

9970 Central Park Boulevard • Suite #400
Boca Raton, Florida 33428
(561) 483-1600 • Fax: (561) 451-4732

❑ Dominic Kleinhenz, M.D. ❑ Bruce Young, M.D. ❑ William McKay, M.D.
❑ David Padden, M.D. ❑ Ricardo Matos, M.D. ❑ Kathryn Heim, M.D.

PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

I hereby authorize Dr._____ or associates or assistants of his choice to perform upon me the named patient the following operations and/or procedures: _____

_____

Dr. _____ or associate has explained to me the nature and purpose of the operation/procedure and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as, possible alternatives to the proposed treatment, including no treatment. I have been given an opportunity to ask questions, and all of my questions have been answered satisfactorily. I understand that during the course of the operation or procedure, unforeseen conditions may arise which necessitate process different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above named physician or his associate or assistants may consider necessary.

I further consent to the administration of such anesthetics and/or blood transfusions which may be considered necessary. I understand that there are risks to life and health associated with anesthesia and blood transfusions. Any organs or tissue surgically removed may be examined or retained by the hospital for medical, scientific or educational purposes and parts may be disposed of in accordance with accustomed practice. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made concerning the results intended from the operation or procedure. I confirm that I have and fully understand the above and that all blank spaces have been completed prior to my signature.

_____ _____

Signature: Patient must sign unless legally incompetent, in that event nearest relative or guardian. Print Name

_____ _____

Witness Signature Print Name

PHYSICIAN'S INFORMED CONSENT

I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to the proposed procedure/operation. I have offered to answer any questions and have answered all such questions. I believe that the patient/relative/guardian understands what I have explained and answered.

Physician's Signature:_____ Date: _____

Holy Cross Medical Group

Holy Cross Medical Group, an Outpatient Division of Holy Cross Hospital

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PATIENT SURGICAL INFORMATION

Patient: _____

You are scheduled for surgery on _____ at _____ ❑ AM ❑ PM at:

❑ **Holy Cross Hospital** • 4725 North Federal Highway • Fort Lauderdale, FL 33308 • **(954) 771-8000**

❑ **Holy Cross HealthPlex** • 1000 Northeast 56th Street • Fort Lauderdale, FL 33334 • **(954) 958-0606**

❑ **North Broward Medical Center** • 201 East Sample Road • Pompano Beach, FL 33064 • **(954) 941-8300**

❑ **West Boca Medical Center** • 21644 State Road #7 • Boca Raton, FL 33428 • **(954) 488-8000**

❑ **Boca Raton Outpatient Surgery and Laser Center** • 501 Glades Road • Boca Raton, FL 33432 • **(561) 362-4400**

On the Day of Your Surgery, Report to the Outpatient Admitting Office at _____ ❑ AM ❑ PM

** **IT IS IMPORTANT THAT YOU DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT** **

Your Pre-Op Testing will be done at _____

_____

Your Next Appointment is Scheduled Here on _____

**** Please note that if you are a member of an HMO or are required to obtain a referral from your primary care physician for a visit, one WILL BE REQUIRED for this visit. ****

Your doctor has requested that you donate _____ unit(s) of blood for yourself prior to surgery.

Date: _____ Time: _____ LOCATION: _____

Date: _____ Time: _____ _____

**** BE SURE TO EAT A GOOD MEAL FIRST ****

If you have any questions or need to change any of the above appointments, please contact your Surgery Coordinator _____ at _____

OTHER INFORMATION OR NOTES,
PLEASE REFER TO ADDRESS AND PHONE NUMBER ABOVE.

Holy Cross Medical Group

Holy Cross Medical Group, an Outpatient Division of Holy Cross Hospital

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Dominic Kleinhenz, M.D. • Thomas Goberville, M.D. • William McKay, M.D.
Bruce Young, M.D. • David Padden, M.D. • Ricardo Matos, M.D.

LIGHTHOUSE ORTHOPAEDIC ASSOCIATES

1821 N.E. 25th Street
Lighthouse Point, Florida 33064
(954) 942-0321 • Fax: (954) 946-7018

9970 Central Park Boulevard South • Suite #400
Boca Raton, Florida 33428
(561) 483-1600 • Fax: (561) 451-4732

POST OPERATIVE INSTRUCTIONS

1. May walk around, use crutches and/or walkers if prescribed.
2. Take your usual medications.
3. Eat normally.
4. Leave dressing on till post operative appointment, unless otherwise directed.
5. You will receive prescriptions for pain medication. Take them as directed.
6. Do not be concerned if the area of the surgery or nearby areas become black and blue. This will go away in a few weeks.
7. If the area of the surgery becomes red, hot or inceasingly more painful call our office.
8. If you have a temperature of 100 or more take 2 Tylenol tablets and call our office in the morning. If your temperature is 102 or greater, call us at that time.
9. You may drive when cleared by the doctor. Do not drive if you are taking pain medication.
10. You may take a mild laxative. Try to avoid straining to have a bowel movement.
11. If you have further questions or if you do not feel your progress is proper call our office.

HOLY CROSS MEDICAL GROUP
LIGHTHOUSE ORTHOPAEDICS
COMPREHENSIVE MUSCULOSKELETAL CENTER

*Dr Dominic Kleinhenz MD
*Dr David Padden MD
*Dr Bruce Young MD
*Dr William McKay MD
*Dr Ricardo Matos MD

1821 NE 25TH ST
LIGHTHOUSE PT., FL 33064
954 942-0432 FAX

954 942-0321

Dear Surgery Patient:

If you are presently taking any of the following medications, please discontinue them **one week** before surgery.

If you take anti-coagulants, please check with your prescribing doctor for instructions on when to stop before surgery.

If you take any medications not listed below, that can promote bleeding, please call your prescribing physician. Such medicines, herbal products or vitamins should have precautions listed on the bottle (if they can increase bleeding).

Aspirin (and products which contain aspirin)
NSAIDs (Advil, Aleve, Motrin, Naprosyn, Orudis, Anaprox, Ansaid, Indocin, Lodine, Toradol, Voltaren, Mobic, Celebrex, Ibuprofen) and any other NSAID not listed.

MAO Inhibitors (Clorgyline, Moclobenide, Isocarboxazid, Phenelzine, Tranycypromine, Selegiline, Meridia, St John's Wart

Anti-coagulants (Coumadin, Plavix, Heparin, Lovenox, Ticlid) any other "blood thinner"

Other over the counter products (Fish oil, CoQ10, Vitamin E)

Tylenol may be taken for pain, if needed.

If you have any questions, please call our Lighthouse Pt Office @ 954 942-0321, and ask for your surgery coordinator.

Holy Cross Hospital

The surgeons and Associates of the Holy Cross Hospital are working hard to prevent infections especially in our patients undergoing orthopedic surgery. Did you know you can help?

By taking an active role in your health you can help us in preventing infection? Skin is not sterile which is why we need skin as free of germs as possible before surgery. Although you may receive antibiotics before or during surgery, thoroughly washing skin the night before surgery and the day of surgery can greatly reduce the number of germs and help reduce the risk of infection.

The Center for Disease Control (www.cdc.gov) recommends use of a special soap called chlorhexadine gluconate (CHG) also known as Hibiclens®. Hibiclens® or any other brand may be purchased at most pharmacies including CVS or Walgreens.

This product should not be used if you are allergic to (CHG)

Following these simple instructions will reassure you your skin is clean before surgery. Read the manufacturer's instructions before using CHG.

1. Shower or bathe with regular soap and water first and rinse thoroughly to remove residue. You may wash your hair as usual with regular shampoo again rinse thoroughly.
2. Apply the Hibiclens® soap to your entire body ***from the neck down only.*** To avoid permanent injury do ***not*** use Hibiclens® near the eyes or ears. Do not ingest Hibiclens. For accidental ingestion contact the **Poison Control Center at 1-800-222-1222**
3. Wash thoroughly paying special attention to the site where your surgery will be performed.
4. Turn off water to avoid rinsing too soon. Keep the product on your skin for at least 5 minutes before rinsing.
5. Do not scrub too hard and do not use regular soap after using CHG.
6. Turn the water back on and rinse your body thoroughly.
7. Pat dry using a clean soft towel.
8. Do not apply any powders, deodorants or lotions and dress in freshly washed clothes.
9. Repeat steps 1 – 8 the morning of surgery.