Surgery Packet for Upcoming Surgery at Surgical Center of the Rockies

The team at the Surgical Center of the Rockies is excited that you have selected our center for your surgery. Our facility is located at…

The Center
2446 Research Parkway, Ste. 100
Colorado Springs, CO 80920
719-418-4244

****If you have MEDICAID or have applied for MEDICAID please call us at 719-418-4244 and ask to speak to Kim or Stacy to have this information updated.****

Please complete the checklist below to make the process easier for you.

- **Pre-Op Call** - A nurse will call you a few days in advance to go over your medical history, and to give you additional and specific pre-op instructions. You will be given a time of arrival on the business day before your surgery.

- **Insurance Verification** - If you owe a deductible/copay/coinsurance on your day of service, our Insurance Verification Department will be giving you a call. If you would like to know ahead of time, please feel free to call our Insurance Verification Department at 719-694-5881. Please note that you will receive separate bills from the facility, your surgeon, and your anesthesiologist.

- **PRINT THE ATTACHMENTS as noted below, if you are unable to print, please review and be prepared to complete on arrival:**
  - **Surgery Packet – for all patients:** please print all 6 pages for review, bring completed pages 4-6 on your day of surgery.
  - **Tricare patients only:** bring completed pages 2-3 on your day of surgery
  - **Cigna patients only**: review this letter from US Anesthesia Partners

- **TO BRING ON YOUR DAY OF SURGERY:**
  - Completed attachment pages, as noted above (if you are unable to print, be prepared to complete on arrival)
  - Photo ID
  - Insurance card (if applicable)
  - Method of payment (if applicable)

Our goal is to provide an exceptional experience for you and your family member accompanying you on the date of surgery. Please note this email is not routinely checked, if you have questions, do not respond to this email, instead please contact us at 719-418-4244 so that we may assist you. We look forward to seeing you soon.

Your Surgical Center of the Rockies Team

2446 Research Parkway, Ste.100
Colorado Springs, CO 80920
719-418-4244

Preoperative Instructions & Information

SCA Health

A nurse will call you a few days in advance of your surgery to review your health history and medications, answer questions and give you specific instructions regarding your surgery. Please save our number (719.418.4244) as a contact in your phone so we may reach you. For urgent health questions, a pre-operative nurse can be reached at 719.418.4247.

- SICKNESS: If you are currently or have been sick in the two weeks prior to your surgery, you should contact your surgeon's office and contact a pre-op nurse for evaluation.

- Driver/Responsible Adult: All patients are **required to have a driver/responsible adult** able to take them home and **stay with them for 24 hours** following surgery.

- Surgery Time: You will be texted or called on the business day prior to surgery with your time for arrival. Because surgery times can change, please keep your phone with you in case of any changes to your arrival time, including the day of surgery. You should not have other conflicting plans on the day of your surgery.

- Bring: Photo ID, Method of payment, and completed attachments (if able to print), and anything requested by your surgeon (e.g. slings, boot/surgical shoe, crutches, walker, ice machine, etc.).

- Wear/Prep: Loose fitting clothing, large enough to fit over a bulky dressing. We recommend loose fitting t-shirts and pants/shorts with elastic waistbands if possible. No makeup, lotion or jewelry on the day of surgery. Please remove all piercings prior to arrival. Rings on the same extremity as your surgery will be cut off pre-operatively if not removed prior to arrival. We recommend having a jeweler cut them off prior to arrival (if this is a concern, you may confirm with the pre-operative nurse on your phone call). Please shower or bathe your entire body with soap the night before or morning of the surgery (do not remove any dressing placed by your surgeon).

- After Hours Emergencies/Inclement Weather: If weather, illness, or emergency will prevent you from arriving on the day of surgery, please call 719.418.4244 to let us know. If there is no answer and your surgery is the same or next business day (if after hours), please call 719.418.4255 and leave a message with your name, surgeon, scheduled arrival time, and details of your situation.

DIET & PREPARATION FOR SURGERY: To ensure a safe anesthetic and avoid cancellation of your surgery, please follow the guidelines below.

DAY BEFORE SURGERY (All patients – See specific instructions for patients taking GLP-1 Agonists):

- NO ALCOHOL or RECREATIONAL DRUGS for 24 hours prior to surgery.
- Shower or bathe full body with soap, night before or morning of surgery.
- **If you *do NOT* take a GLP-1 Agonist** (e.g. Ozempic, Wegovy, etc.), you may eat/drink as normal, we recommend adding Gatorade/Powerade as listed below.
- **If you take a GLP-1 Agonist** (e.g. Ozempic, Wegovy, etc.), you may have a light breakfast before 7 AM, and then **BEGINNING AT 7 AM ON THE DAY BEFORE, YOU MAY ONLY HAVE GATORADE/POWERADE** until 4 hours prior to your check-in time for surgery (you may also have water until midnight).

OPTIONAL GATORADE/POWERADE PROTOCOL:
Research has shown that having Gatorade/Powerade prior to surgery helps you to process the anesthesia better and recover faster afterwards. The sugar in the Gatorade/Powerade is part of what helps you to recover faster, so you will gain the most benefit from the full calorie Gatorade/Powerade. Any flavor is acceptable, this Gatorade/Powerade is optional, but other than a sip of water with meds, it is the ONLY THING allowed after midnight on the day of your surgery. You may not substitute for anything else. We recommend that you buy 3 20-ounce bottles and have one with lunch and dinner the DAY PRIOR TO SURGERY, the last one you are allowed to have on the DAY OF SURGERY, you may have up to 20 ounces between midnight and 4 HOURS PRIOR TO CHECK-IN TIME for surgery.

DAY OF SURGERY (All patients):

- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT,** not even water. The only exceptions are a sip of water with medications, or up to 20 ounces of Gatorade/Powerade (see above protocol) that is FINISHED 4 HOURS PRIOR TO CHECK-IN TIME. You may not have any other food, water, candy, including gum or mints.
- **No smoking or chewing tobacco** after midnight on the day of surgery. Doing so may result in your surgery being cancelled or rescheduled.

*****MEDICATION INSTRUCTIONS FOR SURGERY ***Always confirm these instructions with prescribing provider and your surgeon, a nurse will review these instructions with you on your pre-operative health screening call:**

*****PRESCRIPTION BLOOD THINNERS:** Please obtain permission and clearance from your **prescribing provider, as well as your surgeon** on when/if prescription blood thinners should be stopped prior to surgery. These include, but are not limited to: warfarin (Coumadin), clopidogrel (Plavix), rivaroxaban (Xarelto), apixaban (Eliquis), dabigatran (Pradaxa), prasugrel (Effient), ticagrelor (Brilinta), enoxaparin (Lovenox), heparin, and aspirin are *SOME* of the medications included in this category.

SPECIFIC DRUG MEDICATION INSTRUCTIONS (GLP-1 Agonists and SGLT2-Inhibitors, this list includes the most common, there may be new or other medications in these category not listed below):

If taking one of the drugs listed below (GLP-1 Agonists), please **hold one dose prior to surgery and *see specific diet instructions on prior page for the day before surgery*:**

- Dulaglutide (Trulicity)
- Exenatide extended release (Bydureon bcise)
- Exenatide (Byetta)
- Liraglutide (Victoza, Saxenda)
- Lixisenatide (Adlyxin)
- Semaglutide (Ozempic, Wegovy)
- Semaglutide (Rybelsus)
- Tirzepatide (Mounjaro, Zepbound)

If taking one of the drugs listed below (SGLT2-Inhibitors), please **hold 3 full days prior to surgery (surgery is day 4):**

- Jardiance® (empagliflozin)
- Synjardy® (empagliflozin/metformin)
- Farxiga® (dapagliflozin)
- Brenzavvy™ (bexaglifloxin)
- Invokana® (canagliflozin)
- Steglatro® (ertugliflozin)
- Inpefa® (sotagliflozin)

HOLD 7 DAYS PRIOR TO SURGERY: All medications / supplements that are blood thinners:

- This list includes, but is not limited to: ibuprofen (Advil, Motrin), naproxen (Aleve), aspirin***, meloxicam (Mobic), celecoxib (Celebrex), Excedrin, Nyquil, diclofenac (Voltaren), aloe, fish oil, Omega 3, turmeric, vitamin E, cranberry, ginger, garlic, gingko, and many others, please stop optional supplements unless confirmed with surgeon that they are ok to continue.

MEDICATIONS TO HOLD ON MORNING OF SURGERY: On the morning of surgery, except as listed below, you are allowed to take a sip of water with your medications, or you may take with up to 20 ounces of Gatorade as long as it is 4 hours prior to your check-in time. That said, we would like you to **hold the medications below on the morning of surgery:**

- ACE inhibitors (examples: lisinopril, enalapril)
- diuretics (examples: hydrochlorothiazide (HCTZ), spironolactone, chlorthalidone)
- insulin – if you have an insulin pump, leave setting as normal; otherwise skip morning insulin injections and bring with you to surgery
- oral diabetic medications – skip morning dose, unless listed on the "SPECIFIC DRUG" list above

MEDICATIONS TO BRING WITH YOU ON THE DAY OF SURGERY (if you have them):

- insulin
- rescue inhaler
- migraine medications
- restless leg medications
- *Your post-operative prescription(s), if you have picked them up from the pharmacy

of the Rockies

Welcome to Surgical Center of the Rockies!

Please print **ALL** information requested. This form must be complete in order for us to bill your insurance properly.

Name: _____
Last First Middle Initial

Sex: ☐M ☐F **Date of Birth:** ____/____/____ **Age:** _____ **Marital Status** ☐S ☐M ☐D ☐W ☐Sep
SSN: _____ **Driver's License #:** _____ **State:**_____
Home Address: _____ **City, State, Zip:** _____
Home Phone: _____ **Is this your first visit to our surgery center?** ☐Yes ☐No
Employer: _____ **Business Phone:** _____

Insurance Information

Primary Cardholder's Information **(If the Cardholder is also the patient check the same as above box and move onto the next section.)**

☐Primary Cardholder is also the patient/same as above.

Name: _____
Last First Middle Initial

Date of Birth: ____/____/____ **SSN:** _____ **Relation to the patient:** _____
Address: _____ **City, State, Zip:** _____
Home Phone: _____ **Employer:** _____
Business Address: _____ **City, State, Zip:** _____
Business Phone: _____

1. **Is the patient's injury/illness due to a work accident?** ☐ Yes ☐ No
2. **Is the patient's injury/Illness due to a car accident?** ☐ Yes ☐ No
3. **Will your ride wait for you at the surgery center?** ☐ Yes **~OR~ Pick you up after surgery?** ☐ Yes
4. **Name and telephone number of the person providing your ride home:**
   Name: _____ Telephone: _____
5. **Emergency Contact:**
   Name: _____ Telephone:_____
   Relationship to the Patient: _____
6. **Has your surgeon provided you with an informed consent for this surgery?** ☐ Yes ☐ No

I hereby certify that all of the above information is correct:

X_____
Patient or Guardian Date

Permission to Speak to...

of the Rockies

This section is to be completed by Patient/Parent/Guardian/Personal Representative

Surgical Center of the Rockies may speak to the following individuals regarding my healthcare...

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Name: _____ Relationship to the Patient: _____
Phone Number: _____

Surgical Center of the Rockies has my permission to call and leave a message regarding my healthcare at the following numbers...

Home: ☐ Yes #_____ ☐ No

Work: ☐ Yes #_____ ☐ No

Cell Phone: ☐ Yes #_____ ☐ No

Other: _____ ☐ Yes #_____ ☐ No

My signature below indicates I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Surgical Center of the Rockies may use and/or disclose, to the persons/phone numbers listed on this form, my protected health information.

I understand that I may revoke this authorization at any time by given written notice to Surgical Center of the Rockies. I further understand that revocation of this authorization will not affect any action you took in reference to disclosing my protected health information before you received my written revocation notice.

_____ _____
Signature Date

_____
Printed Name

Revocation of permission to speak to...

If you wish to revoke your permission to release your protective health information to the above individuals and phone numbers, please contact Surgical Center of the Rockies at 719-418-4244.

DISCLOSURE OF FINANCIAL INTEREST

You (or your legal representative on your behalf) acknowledge that your physician may participate in one or more quality and efficiency programs operated by your health insurer. These programs provide a financial incentive to participating physicians to achieve certain quality targets and to select cost effective, participating facilities for your care. The facility to which you have been referred is one such participating facility:

Name of Facility: Surgical Center of the Rockies

Address of Facility: 2446 Research Parkway, Ste. 100; Colorado Springs, CO 80920

The incentive payment, which is paid by your health insurer, is in addition to the physician's normal professional fee. If your physician participates in such a quality and efficiency program and that program is applicable to your care at this facility, alternative referrals will be made by your physician upon your request—you have the right to obtain the referred services or items at the facility of your choice, unless otherwise restricted by law. If no request is made, you acknowledge herein that you consent to your physician's choice of facility.

You also acknowledge receipt, on the date indicated below and at the time of this referral, of a copy of this Disclosure of Financial Interest.

You further acknowledge that your physician may own an interest in this facility and/or otherwise may have a financial interest in this facility.

Further information may be obtained from the business office of the facility.

By signing below, I acknowledge that, on the date indicated below, I have read and understand the disclosures set forth above.

PATIENT OR LEGAL REPRESENTATIVE OF PATIENT:

Signature of Patient or Legal Representative: _____

Printed Name of Patient: _____

Date: _____