



# Physician Partners of America

ORLANDO OUTPATIENT SURGERY CENTER

1736 33rd Street, Orlando, FL 32839

Phone: 407-233-1543

Fax: 813-200-2207

Administrator: April Hansard

Welcome to Orlando Outpatient Surgery Center! We are excited to accommodate your outpatient surgery cases and provide your patients with excellent patient care.

Below is the facility information that your surgery scheduler will need to book cases with us.

NPI Number: 1225517279

Tax ID: 82-1372628

Medicare Number: 10C0001641

#### Insurances Accepted:

- We are Medicare certified and can accept all government payors.
- We gladly accept LOP, worker's comp and auto cases.
- We offer competitive self-pay rates. Please contact us for a self-pay rate for a specific CPT code.
- Please do not hesitate to contact us with any questions concerning insurances. Even if a patient does not have OON benefits, we can try obtain a special authorization to perform the procedure at our facility.

To schedule a case with us, please call the main scheduling line (407-233-1543) and request to speak to our dedicated ASC scheduler, Gabrielle Collazo, or you may email her below:

[GCollazo@physicianpartnersoa.com](mailto:GCollazo@physicianpartnersoa.com)

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## ANESTHESIA GUIDELINES FOR SURGERY:

### HISTORY & PHYSICAL:

All Patients must have a history/physical that is 30 days current written by a MD or DO.

### MEDICAL CLEARANCE AND/OR CARDIAC CLEARANCE DEPENDS ON PATIENTS' HEALTH HISTORY:

Cardiac patients will need cardiac clearance and a copy of an EKG within past 6 months.

Patient with co-morbidities (Hypertension, High Cholesterol, Diabetes, etc.) will need a medical clearance from their primary care physician or specialist.

### ALL PATIENTS HAVING GENERAL ANESTHESIA:

Labs: CBC, CHEM 7, PT, INR, PTT (within 1 month of the date of surgery)

### PATIENTS OVER 50 YEARS OLD:

EKG required

### DIALYSIS PATIENTS:

Serum Potassium 24 hours prior to surgery or post dialysis

### MEDICATIONS TO STOP BEFORE SURGERY:

Patients should check with their PCP or surgeon about drugs they should stop before surgery, especially blood thinners (i.e. ASA, Plavix, Coumadin, etc.). We recommend stopping ACE Inhibitors one (1) day before surgery (Lisinopril, Captopril, Benazepril and Losartan).

### TESTS PERFORMED ON-SITE THE DAY OF SURGERY:

Urine pregnancy test on post-menarche and pre-menopausal women.

Blood glucose on insulin dependent diabetics.

*Our anesthesiology team reviews all patients' charts prior to their DOS (date of surgery). Occasionally, one of our anesthesiologists may contact you with specific questions regarding your patient's medical history and appropriateness for surgery in an outpatient environment.*

Should you have any questions regarding the above guidelines, please call 407-385-1555 and ask to speak to a pre-op nurse.

# Orlando Outpatient Surgery Center Booking Sheet

SURGERY DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ CASE LENGTH: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ OFFICE #: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SEX: M F  
First Middle Last

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL: \_\_\_\_\_ ALTERNATE #: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_

MARITAL STATUS: M S D W

EMPLOYER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

PROCEDURE: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

EQUIPMENT NEEDED: \_\_\_\_\_

REPS/VENDORS TO BE NOTIFIED: \_\_\_\_\_

ANESTHESIA: GENERAL MAC LOCAL REGIONAL AX BLOCK BIER BLOCK OTHER: \_\_\_\_\_

PRE-OPS AT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

CIRCLE ONE: HMO POS PPO MEDICARE MEDICAID WORKCOMP AUTO LOP SELF-PAY

IF HMO, AUTHORIZATION #: \_\_\_\_\_

CPT CODE(S): 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_ 4: \_\_\_\_\_

ICD-10 CODES: 1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_ 4: \_\_\_\_\_

**\*\*Please provide any/all clinical documentation to support this order including diagnostic imaging reports.\*\***

PLEASE FAX COMPLETED FORM TO 813-200-2207 OR EMAIL TO [GCollazo@PhysicianPartnersoa.com](mailto:GCollazo@PhysicianPartnersoa.com)

# For all LOP/Auto/WorkComp Cases

\*\*\* WILL FACILITY BE HOLDING THE LOP: YES NO

DATE OF ONSET/ACCIDENT REQUIRED: \_\_\_\_\_

ADJUSTER NAME: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

ADJUSTER PHONE: \_\_\_\_\_ EXT. \_\_\_\_\_

PRIMARY INSURANCE CO: \_\_\_\_\_ PHONE #: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

POLICY HOLDER (IF NOT PATIENT): \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

BENEFIT INFORMATION: \_\_\_\_\_

SECONDARY INSURANCE CO: \_\_\_\_\_ PHONE #: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SS#: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

BENEFIT INFORMATION: \_\_\_\_\_

PERSON GIVING INFO: \_\_\_\_\_ DATE OF VERIFICATION: \_\_\_\_\_

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Updated 5/2020

# Orlando Outpatient Surgery Center

## Short Stay History & Physical Form

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

PRE-OP DIAGNOSIS: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

HISTORY (PRESENT ILLNESS, INDICATIONS FOR, AND PROCEDURE PLANNED):

SIGNIFICANT PAST MEDICAL HISTORY:

SURGICAL: \_\_\_\_\_

CARDIOVASCULAR: \_\_\_\_\_

RESPIRATORY: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

DOES PATIENT SMOKE? Y N ETOH: \_\_\_\_\_ OTHER: \_\_\_\_\_

EXAMINATION: B/P: \_\_\_\_\_ P: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

HEART: \_\_\_\_\_ LUNGS: \_\_\_\_\_

SURGICAL CONDITION: \_\_\_\_\_

PRE-OP ORDERS — CONSENT FOR: \_\_\_\_\_

I CERTIFY THAT THE PATIENT MEETS ALL ADMISSION CRITERIA AND IS A CANDIDATE FOR  
PLANNED ANESTHESIA AND PROCEDURE IN THIS AMBULATORY SURGERY CENTER.

\_\_\_\_\_  
Physician Signature

ANESTHESIA PRE-OP ORDERS: \_\_\_\_\_

\_\_\_\_\_  
Anesthesiologist Signature

OPERATION/PROCEDURE FINDINGS: \_\_\_\_\_

POST-OP DIAGNOSIS: \_\_\_\_\_ ANESTHESIA: \_\_\_\_\_

POST-OP ORDERS: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

PATIENT LABEL