Alexis Chiang Colvin, M.D.
Assistant Professor, Orthopaedic Surgery
Sports Medicine

Leni & Peter W. May
Department of Orthopaedic Surgery

The Mount Sinai Medical Center
One Gustave L. Levy Place, Box 1188
New York, NY 10029-6574
Tel: (212) 241-1815
Fax: (212) 534-6202

DATE: _____

Dear _____:

You have been scheduled for _____ on: _____

Report to: 1468 Madison Ave & 100th Street, Guggenheim Pavilion 2nd Floor

Please call me on _____ at 1:00 pm to confirm your admission time.

Please Note: Hospital policy states that you must arrive 2 HOURS prior to the start of your operation.

Enclosed you will find:

1. List of the required tests to be completed before your surgery. Please contact your primary care physician to schedule an appointment. In order for you to have the scheduled surgery, you must be cleared medically by your primary care physician. Your physician **MUST** fax all blood test results and the history & physical report to Dr. Colvin at least one week prior to surgery to (212)534-6202.

2. Crutches:
   a) If you were given a prescription for crutches, you must obtain them from a pharmacy or medical supply store. The Hospital does not provide crutches.
   b) If you were given a prescription for crutch training, please call the number on the prescription to ensure someone will be there to train you. No appointment is necessary. Crutch training is located at 1190 Fifth Avenue, MC Level Rm 201.

If you have x-rays (MRI Scan, CT scan) in your possession regarding your condition, you must also bring them with you on the day of surgery.

If you are taking medication(s), let the prescribing physician know that you are scheduled for surgery. Ask the physician if you should continue taking your medication(s) as prescribed. **IF YOU ARE ALLERGIC TO ANY MEDICATION(S) PLEASE LET US KNOW AS SOON AS POSSIBLE.**

DO NOT EAT OR DRINK ANYTHING **after 12:00 midnight on** _____, **&**

_____, **THE MORNING OF SURGERY.**

If you are taking Aspirin or any Motrin-like medications, please stop 10 days prior to surgery, unless otherwise instructed. Medications may be taken the morning of Surgery with a sip of water. If you are Diabetic, do not take Glucophane within 24 hours of your Surgery.

Should you wish to discuss any of the above, do not hesitate to contact me at 212-241-1815.

Sincerely,

_____
Administrative Assistant to Dr. Colvin

Alexis Chiang Colvin, M.D.
Assistant Professor, Orthopaedic Surgery
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Date: _____

Patient Name: _____

Date of Surgery: _____

Procedure: _____

Dear Health Care Provider:

Listed below are the tests required for pre-admission testing for day of admission surgery to Mount Sinai Medical Center. **Pre-testing must be done no more than 30 days before the surgery date.** Please perform whatever is circled, all test results and the history and physical report **must be faxed** to Dr. Alexis Chiang Colvin at least three days prior to the scheduled surgery to (212) 534-6202. If you have any questions, feel free to contact me at (212) 241-1815 (PLEASE USE THE ATTACHED FORM FOR THE HISTORY AND PHYSICAL REPORT)

_____ SMA-18

_____ CBC with Platelets and Differential

_____ History and Physical (full systems review)

_____ EKG (**pts age 50 years or older and/or if requested by anesthesia)**
(EKG should be within 6 months if the results are normal)

_____ Chest X-ray **(pts 70 years or older and/or if requested by anesthesia)**
(Chest x-ray should be within one year if results are normal)

_____ Beta HCG **(Mandatory for women between the ages of 13 – 55 years)**

_____ Other_____

Thank you for your cooperation.

Sincerely,

_____
Administrative Assistant to Dr. Colvin

Mount Sinai

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, New York 10029

PRE-PROCEDURE HISTORY & PHYSICAL EXAMINATION

PATIENT HISTORY

Proposed Procedure(s):

Chief Complaint/History of Present Illness:

Past Medical History:

Past Surgical History:

Social/Occupational History:

Substance Use: Tobacco: Alcohol: Other:

Last Menstrual Period:

Allergies

Medications / Herbals

PHYSICAL EXAMINATION

Head/Eyes/Ears/Nose/Throat/Airway:

Cardiovascular:

Pulmonary:

Abdominal:

Extremities:

Neurological:

Physiologic Data

Height:	cm
Weight:	kg
BP:	mmHg
Pulse:	/min
Resp:	/min
Temp:	°C

LABORATORY DATA & STUDIES

INR:
PT:
PTT:

CXR: Other:

ECG:

ASSESSMENT & PLAN

Name: Dictation #: Signature: Date: Time:

IMMEDIATE PREOPERATIVE REASSESSMENT

I have reviewed the above evaluation, I have re-evaluated the patient immediately prior to the procedure, and I have found:
☐ No significant interval change in his/her condition ☐ Significant change which I have documented in the Medical Record

Name: Dictation #: Signature: Date: Time:

The Mount Sinai School of Medicine
5 East 98th Street
9th Floor
New York, NY 10029

Department of Orthopaedic Surgery

Dear Patient,

Thank you for electing to have surgery under the care of our provider.

Please note that there will be three (3) components to your surgery charges: Surgeon(s), Hospital and Anesthesia. Each department will bill you and/or your insurance company separately. For questions regarding the charges billed, you may contact the following departments:

1. **Department of Orthopaedics Surgeon's bill**: (212) 241-6980
2. **Mt. Sinai Hospital Outpatient/Ambulatory billing**: (212) 731-3800

   or

   Mt. Sinai Hospital In-Patient billing: (212) 731-3100
3. **Anesthesiology billing**: (800) 627-4470

Please be aware that if there is a co-surgeon involved in the surgery, you will be billed separately for their charges and should contact the billing phone number listed on the statement you receive from them. The Department of Orthopaedics will only be able to assist with charges for our department's surgeon only.

The surgeon's office will obtain authorization for your surgery but authorization is not a guarantee of payment and therefore you should contact your insurance carrier prior to the surgery. It is your responsibility to be aware of their terms of coverage for the surgery.