



THOMAS M. ANDREWS, M.D. • WADE R. CRESSMAN, M.D.

PETER W. OROBELLO, M.D. • ROSE C. STAVINOHA, M.D. • KATHLEEN M. WASYLIK, M.D.

Telephone: (727) 329-5400

Web Site: www.pediatric-ent.com

PREOPERATIVE CHECKLIST

1. Stop giving your child aspirin or ibuprofen (Advil, Motrin and Aleve) two weeks before surgery. **Tylenol is OK.**
Continue all other medications as prescribed.
2. Please contact our **surgery scheduler** immediately with any change in phone numbers or insurance policies. **(727-329-5397)**
3. If you were given a prescription for pre-operative lab work, please have it drawn between 3-5 days before the day of surgery.
4. Anesthesia prefers NO vaccinations be given within 2 weeks of the surgery.
5. Please contact the **nurses at** Pediatric Ear, Nose & Throat Specialists if your child develops RSV, Pneumonia, Bronchitis or is exposed to Chicken Pox within 3-weeks of surgery. **(727-329-5398)**
6. The Pre-Admission nurses from the **Surgical Facility** will contact you by phone a day or two before surgery. They will need to speak with you to review your child's health history for the anesthesiologists. They will also have your child's preoperative instructions and guidelines for when to stop eating and drinking.
7. Please bring **your** photo ID and **your child's** insurance card with you the day of surgery. A parent or legal guardian **must** accompany the child on the day of surgery (we must have copies of any legal paperwork **ahead** of time for children not accompanied by adoptive or biological parents).
8. If your child uses a nebulizer or inhaler, please give a treatment prior to leaving home the day of surgery and bring puffers.
9. If you have a prescription from your pediatrician or another specialist for labs to be drawn in surgery, please notify the surgery center 1-2 days prior to the surgery. The surgery center is not able to process all labs, and some labs will change your child's NPO instructions.

Photo ID Required at Check In



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AFTER HOURS INFORMATION

Our office hours are Monday through Friday from 8:00 a.m. to 5:00 p.m.

If a problem occurs after our regular office hours, please call our **answering service @ (727) 562-6858**.

Tell the Telephone operator which doctor is currently treating your child. (It is marked below for you). This will help to serve you and your child in a more expedient manner.

Thank you.

Thomas M. Andrews, M.D.	_____
Wade R. Cressman, M.D.	_____
Peter W. Orobello, M.D.	_____
Rose C. Stavinoha, M.D.	_____
Amy A. Ashburn, ARNP	_____
Claudia Botero, C-PA	_____
Lacey T. Hodgson, ARNP	_____
ENT Resident	_____

Under your physician's recommendation, your child may be seeing our physician's assistant or nurse practitioner for his or her post-operative visit and follow up care.



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ACCESSING OUR SURGERY VIDEOS BY INTERNET

1. Log onto www.pediatric-ent.com
2. Select “**Learning Center**” located in the top blue bar. It is a ‘**Single Click**’.
3. Select “Surgeries We Perform” located at the top of the page in **RED** lettering. A ‘**Single Click**’.
4. Go to the procedure that is being performed on your child.
(**The four (4) listed below have videos you may watch.**)
 - a. Ear Surgery (watch video)
 - b. Sinuses: Endoscopic sinus surgery (watch video)
 - c. Tonsillectomy (watch video)
 - d. Tympanostomy Tubes (watch video)
5. **Single click on (watch video).**
6. The video will begin.
7. If you would like more information on the actual procedure being performed, **single click on the name of the procedure** that appears in front of (watch video).

You are also able to access the post-operative instructions for that procedure by going to ‘**post-operative instructions**’, located at the bottom of the page. It is in **RED** lettering and takes on a ‘Single Click’. Go to the surgical procedure being performed on your child. (Adenoidectomy, Endoscopic Sinus Surgery, Palatoplasty, Tonsillectomy or Tympanostomy Tube Placement).

We hope this information is helpful for you and your child. If you have any questions, please do not hesitate to call our **nursing department @ (727) 329-5398** and we will be happy to assist you.

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IMPORTANT INSURANCE INFORMATION

Prior to your child's surgery, our Insurance Specialist will be in contact with your insurance company. Benefits will be verified and prior authorization will be obtained (if required).

If authorization is required, the authorization number will be passed over to the surgery center or hospital and will be place for your arrival by the date of surgery.

Our office is billing your insurance as a courtesy to you, therefore confirmation of benefits and/or authorization is **NOT A GUARANTEE OF PAYMENT.**

Your insurance policy is a contract between you and your insurance carrier. We wi II not become involved in disputes between you and your carrier regarding preexisting condition clauses, deductibles, co-payment, non-covered charges and "usual and customary fees". We will supply factual information to your insurance carrier upon written request from them.

If we are advised by your carrier prior to the surgery date that your calendar year deductible **HAS NOT BEEN MET FOR THE YEAR**, we request that you contact our office regarding payment arrangements.

If you are unable to pay this deductible in full, we can work out a payment arrangement.

IF YOU HAVE QUESTIONS OR CONCERNS, WE WELCOME YOU TO CALL OUR INSURANCE SPECIALISTS@ (727) 329-5338 or (727) 329-5339.

PEDIATRIC SURGERY CENTERS LLC
TAMPA FLORIDA
History & Physical - Short Form

Chief Complaint:			Date of Examination:						
History of Present Illness:			WT:		HT:				
			TEMP:		PULSE:				
			RESP:		BP:				
Recent illness: No <input type="checkbox"/> Yes <input type="checkbox"/>									
Past Medical History									
Prematurity: No <input type="checkbox"/> Yes <input type="checkbox"/>									
Medical Problems: No <input type="checkbox"/> Yes <input type="checkbox"/>				Previous Surgery: No <input type="checkbox"/> Yes <input type="checkbox"/>					
Hospitalizations: No <input type="checkbox"/> Yes <input type="checkbox"/>				Medications: No <input type="checkbox"/> Yes <input type="checkbox"/>					
Family/Social History: No issues identified <input type="checkbox"/>				ROS:					
Recent exposure to Infectious disease: No <input type="checkbox"/> Yes <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other <input type="checkbox"/>									
Allergies: NKA <input type="checkbox"/> Yes <input type="checkbox"/>									
Immunizations: Up to date <input type="checkbox"/> Delayed <input type="checkbox"/>									
Bleeding Disorders: No <input type="checkbox"/> Yes <input type="checkbox"/> Sickle Cell Status: Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unknown <input type="checkbox"/>									
Anesthesia Reactions: No <input type="checkbox"/> Yes <input type="checkbox"/>									
Developmental: WNL <input type="checkbox"/> Delayed <input type="checkbox"/>									
Physical exam:		WNL		Abnormal		Not Examined		Comments: (Explain all abnormal findings)	
General		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Head		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Ears		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Nose		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Mouth/Throat		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Neck		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
CV		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Lungs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Abdomen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
GU/Rectal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Extremities		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Neuro		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Skin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Impression:				Labs:					
Plan:				Other:					
Preop Dx:				Indication for Surgery:					
Postop Dx:				Time:					
Procedure:				Date:					
Assistant: None <input type="checkbox"/>				Examiner/MD Signature					
Findings:				Patient ID					
Complications: None <input type="checkbox"/>				PLACE CHART LABEL HERE					
EBL: None <input type="checkbox"/> <10cc <input type="checkbox"/> Other amt:									
Specimen(s) removed: Yes <input type="checkbox"/> No <input type="checkbox"/>									
Rx given: Yes <input type="checkbox"/> No <input type="checkbox"/> Discharge instructions given: Yes <input type="checkbox"/> No <input type="checkbox"/>									
Disposition: Home <input type="checkbox"/> Follow-up:									