

Patient Name (Last, First):
DOD ID Number:
Date of Birth:



DEFENSE HEALTH AGENCY NATIONAL CAPITAL REGION

Patient Name: _____

PRE-PROCEDURE PACKET

Prior to being seen or contacted for your anesthesia prescreen, the following need to be completed:

1) Patient Registration Form

2) Surgical Consent

3) Blood Consent (optional)

Type and Screen/Type and/or Cross ordered

4) Anesthesia Pre-op Questionnaire

5) Privacy Act Statement

6) Third Party Collection Program/Other Health Insurance, DD Form 2569 (only for non-active duty, completed every 12 months)

Surgery Location [check one]

FBCH

dha.belvoir.fbch.mbx.apu-surgical-packets@mail.mil

KACC

MGMC

usaf.jbanafw.11-mdg.mbx.preadmissions@mail.mil

WRNMMC

dha.bethesda.j-11.mbx.wrnmmc-apu-pre-op-packet@mail.mil

CLINIC STAFF USE ONLY – MANDATORY

CLINIC PROVIDER NAME & CONTACT#: _____

Is the patient currently undergoing disability evaluation? If yes, contact surgeon for required clearance documentation from chain of command.

APU Preoperative Appointment for Anesthesia Appt Date: _____

Appropriate for T-Con Surgery Date: _____

Chart Reviewed and Complete

Staff Initials/Time/Date: _____

APU Deficient Tracking Tool

Date:	Deficit Code:	Service:	Physician:	Notes:

A: Incomplete forms

B: Pre-Procedure Testing missing

C: Missing Orders

D: Missing Content

E: No Essentris Chart/Orders

F: Wrong classification

Patient Name (Last, First):
DOD ID Number:
Date of Birth:

PATIENT REGISTRATION FORM

(Please fill out this form completely)

Registration Clerk: _____ Date: _____

Patient Information:

Name (Last, First Middle): _____

Sponsor's SSN: _____ Your SSN: _____ Sex:

DOD ID#: _____ Religious Preference: _____ DOB: _____

Ethnicity (check one): Filipino Hispanic Southeast Asian Asian/Pacific Islander Other: _____

Race (check one): Asian Black Western Hemisphere Indian White Other: _____

Marital Status (check one): Annulled Divorced Interlocutory Legally Separated Married Single Widowed

Home Address: _____

State: _____ Zip Code: _____ Primary Phone: _____ Secondary Phone: _____

For Active Duty: Are you currently undergoing disability evaluation through the disability evaluation system? Yes No

Emergency Contact Information:

Name (Last, First MI): _____ Relationship: _____

Address: _____

State: _____ Zip Code: _____ Best Contact Phone: _____

Next-of-Kin Information:

Same as Emergency Contact

Name (Last, First MI): _____ Relationship: _____

Address: _____

State: _____ Zip Code: _____ Best Contact Phone: _____

Sponsor Information:

Same as Emergency Contact

Same as Next of Kin

Name (Last, First MI): _____ PRP/PSP/Flying Status:

Service: _____ Rank: _____ MOS/Rate/AFSC _____

Command: _____ Length of Service: _____

Duty Address: _____

State: _____ Zip Code: _____ Duty Telephone: _____

Other Health Insurance: (Please do not include TRICARE)

Are you covered by private health insurance: Yes No If Yes, notify Patient Administration (PAD)

I certify that the information on this form is complete and correct to the best of my knowledge.

Patient Signature

Date



DEFENSE HEALTH AGENCY NATIONAL CAPITAL REGION

Pre-Surgical/Procedural Additional Information Form

Please use this space to fill out any additional information that was not able to fit on other forms.

Patient Name (Last, First):

DOD ID Number:

Date of Birth:

Anesthesia Preoperative Questionnaire

Patient's Name: Last, First MI	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Other	Ht: _____ in	Wt: _____ lbs	STAFF USE BMI: _____
Sponsor's SSN:	Rank:	Primary Phone:			
DOD ID:		Secondary Phone:			

1. Do you have, have you ever had, or been told you had any of the following:

	Y	N		Y	N		Y	N
1. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	14. Pacemaker and/or Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	27. Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
2. COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	15. Heart Stent	<input type="checkbox"/>	<input type="checkbox"/>	28. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
3. Home Oxygen Use	<input type="checkbox"/>	<input type="checkbox"/>	16. Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	29. Bleeding Disorder/Low Blood Count/Anemia	<input type="checkbox"/>	<input type="checkbox"/>
4. Recent Flu/Cold/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	17. Other Heart Disease/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	30. Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>
5. Sleep Apnea <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>	<input type="checkbox"/>	18. Communicable Disease (e.g. HIV, Hep B, Hep C)	<input type="checkbox"/>	<input type="checkbox"/>	31. Personal or Family History of Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
6. CPAP Use	<input type="checkbox"/>	<input type="checkbox"/>	19. Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	32. Psychiatric disease	<input type="checkbox"/>	<input type="checkbox"/>
7. Significant Snoring	<input type="checkbox"/>	<input type="checkbox"/>	20. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	33. Significant Disability	<input type="checkbox"/>	<input type="checkbox"/>
8. Other Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	21. Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	34. Born Prematurely	<input type="checkbox"/>	<input type="checkbox"/>
9. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	22. Frequent Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	35. Developmental Delay/ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
10. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	23. Esophageal/Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>	36. Allergies (Food, Medications, Latex)	<input type="checkbox"/>	<input type="checkbox"/>
11. Heart Valve Problems	<input type="checkbox"/>	<input type="checkbox"/>	24. Liver/Gallbladder/Pancreatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	37. Difficult Airway or Failed Intubation	<input type="checkbox"/>	<input type="checkbox"/>
12. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	25. Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	38. Multidrug Resistant Organisms (MRSA, VRE)	<input type="checkbox"/>	<input type="checkbox"/>
13. Irregular Heartbeat or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	26. Spinal/Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	39. <i>Females Only:</i> Any Gynecological Disease	<input type="checkbox"/>	<input type="checkbox"/>

2. Please explain any "Yes" answers with corresponding number above in detail. Use extra form if needed.

3. Do you have any specific concerns or questions regarding the anesthesia portion of your surgery? Yes No

If yes, please explain: _____

**** See reverse to complete questionnaire ****

For Administrative Purposes

Signature _____

Signature _____

APU Prescreen Personnel

Anesthesia Provider

MEDICAL RECORD

**REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

A. IDENTIFICATION

1a. (Check all applicable boxes)		1b. DESCRIBE
<input type="checkbox"/> OPERATION OR PROCEDURE	<input type="checkbox"/> SEDATION	
<input type="checkbox"/> ANESTHESIA	<input type="checkbox"/> TRANSFUSION	

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are: _____
(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

- a. The name of the patient and his/her family is not used to identify said pictures.
- b. Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.
(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Patient)

(Date and Time)

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____
sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

PATIENT'S IDENTIFICATION <small>(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)</small>	REGISTER NO.	WARD NO.
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**REQUEST FOR ADMINISTRATION OF ANESTHESIA
AND FOR PERFORMANCE OF OPERATIONS AND
OTHER PROCEDURES**

Medical Record

OPTIONAL FORM 522 (REV. 7/2008)

Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)

DoD Exception to OF 522 approved by GSA

Patient Name (Last, First):
DOD ID Number:
Date of Birth:

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEH); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: <http://dpcl.d.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx>.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR

6. SOCIAL SECURITY NUMBER OR
DOD IDENTIFICATION NUMBER
OF MEMBER OR SPONSOR

7. DATE (YYYYMMDD)

**BLOOD TRANSFUSION
PATIENT INFORMATION AND CONSENT FORM**

Dear Patient,

During the course of treatment you may need to receive blood or blood products. You should feel free to ask your doctor why you may need a transfusion. Benefits of transfusion include: (1) to improve oxygen delivery to your organs, (2) to replace factors or cells that help stop bleeding, or (3) to provide proteins (called globulins) to help your immune system, or (4) other reasons your doctor will explain. While many precautions are taken to make blood products safe, there are some well-known risks, including but not limited to, those listed below.

1. Transmission of infectious diseases: All blood for transfusion in the U.S. is tested for the following infectious diseases: HIV 1 & 2, HTLV I & II, Hepatitis B & C, syphilis, Chagas, and West Nile Virus. Only units that are negative for all of these tests are allowed to be transfused. Although these tests are extremely sensitive, on very rare occasions, a unit will contain a low level of virus that cannot be detected with current testing methods. There are diseases for which no approved test yet exists or there may be infectious risks, as yet unknown to us, that could be transfusion-transmitted. There is no way to guarantee a zero-risk transfusion, however, research and development of more sensitive tests are ongoing. As better testing methods are introduced into the blood banking industry, it is possible that transfusion recipients could be contacted in the future by their blood bank for follow-up information or blood samples. Your cooperation, should this occur, would be completely voluntary, and your participation could contribute to improvement in the safety of the nation's blood supply.

2. Fever: Transfused blood products can cause fever in some individuals.

3. Allergic reactions: After blood transfusion a person may occasionally experience wheezing, itching, low blood pressure, swelling in the throat, or breathing problems.

4. Hemolytic reactions: A potentially serious reaction can occur if you receive a unit of blood that is of a different ABO type from your own. Even when ABO-compatible blood is given, delayed hemolytic reactions can occur if the transfused red blood cells stimulate your immune system to make antibodies against them a few days to weeks following transfusion. This usually causes the transfused red blood cells to be destroyed in your spleen, resulting in a mild temporary jaundice (yellowing of the skin).

5. Transfusion-related acute lung injury (TRALI): A potentially fatal reaction involving lung damage has been reported in some recipients of cellular blood products and fresh frozen plasma. This reaction is not well understood and is being actively studied. It is believed the reaction is related to either an agent in the blood of certain donors, particularly females who have been pregnant in the past, or an agent that accumulates in some units of blood as they age. TRALI is manifested by difficulty breathing and fever within 1 to 6 hours after transfusion. Most victims fully recover, but in some cases the reaction is severe enough to cause death.

The above complications are rare, but potentially life-threatening. The estimated risks of these complications are shown in the table on the next page.

6. For surgical patients: Under special circumstances, your surgeon may determine that it is necessary or desirable to use a technique called Intraoperative Red Cell Salvage. This technique uses specialized equipment that harvests and washes your lost surgical blood and prepares it for transfusion. Use of this blood is an effective means to reduce the use of banked blood, decreasing the likelihood of transfusion reactions and spread of infectious disease. Drawbacks to this method include the need for anticipated large blood loss volumes, non-applicability to all types of surgery, and the potential spread for certain types of malignancy.

Patient Name (Last, First):

DOD ID Number:

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**BLOOD TRANSFUSION
PATIENT INFORMATION AND CONSENT FORM**

ESTIMATED RISKS OF SOME TRANSFUSION COMPLICATIONS

TRANSFUSION RISK FOR EACH UNIT RECEIVED	RISK	REFERENCES
Febrile reaction ¹	1 : 60 ^a	^a Estimated to be 1:91 with prestorage leukoreduction and 1:46 with poststorage leukoreduction. ^b Indicates the estimated risk per recipient rather than unit. ^c The estimate is variable depending on the length of the infectious period. 1, 2, 3, 4, 5, 6, 7, 8 – Clinical Practice Guidelines From the AABB Red Blood Cell Transfusion Thresholds and Storage, <i>JAMA</i> .doi: 10.1001/jama.2016.9185 ⁹ AABB Association Bulletin #14-04, 18 Jul 2014. ^{10, 11} AABB Technical Manual, 18 th ed., 2014
Transfusion-associated circulatory overload (TACO) ²	1 : 100 ^b	
Allergic reaction ³	1 : 250	
Bacterial Sepsis (from platelets) ⁹	1 : 2,000 to 1 : 3,000	
Delayed hemolytic transfusion reaction ¹¹	1 : 2,500 to 1 : 11,000	
Transfusion related acute lung injury (TRALI) ⁴	1 : 12,000	
Acute hemolytic transfusion reaction ¹⁰	1 : 76,000	
Hepatitis C virus infection ⁵	1 : 1,149,000	
Hepatitis B virus infection ⁶	1 : 1,208,000 to 1 : 843,000 ^c	
Human immunodeficiency virus infection ⁷	1 : 1,467,000	
Fatal hemolysis ⁸	1 : 1,972,000	

The alternatives to transfusion include: (1) not receiving a transfusion, (2) pre-surgical autologous donation, and (3) intraoperative red cell salvage. If you have any questions about transfusion risks, benefits, complications, or alternatives, please discuss them with your doctor **BEFORE** you agree to have any blood transfusion.

1. COUNSELING PROVIDER OR DENTIST: I have counseled this patient as to the proposed procedure(s), attendant risks involved, the expected need for transfusion, and the use of intraoperative red cell salvage (if appropriate).

Provider/Dentist Signature Date Time

2. PATIENT: I understand the risks associated with blood transfusion and the reasons why my doctor(s) may wish to transfuse me. Should my doctor(s) deem a transfusion necessary, I agree to be transfused. For surgical patients only - I understand that intraoperative red cell salvage will / will not (initial one) be used.

Witness Signature Date Time _____
Patient Signature Date Time

3. PARENT/LEGAL REPRESENTATIVE: (When a patient is a minor or unable to give consent)
I, _____, parent/legal representative of _____, understand the nature of the proposed procedure(s), attendant risks involved, and the expected need for transfusion and red cell salvage (if appropriate). I hereby request that such procedure(s) be performed. Should the doctor(s) taking care of this patient deem a transfusion necessary, I agree with their decision.

Witness Signature Date Time _____
Parent/Legal Representative Signature Date Time

Patient Identification

**THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/
OTHER HEALTH INSURANCE**

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires
31 Aug. 2019

The public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0055). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.**

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected; 1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC, Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment Facility. **ROUTINE USE(S):** Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: <http://dpdcd.defense.gov/Privacy/SORNIndex/BlanketRoutineUses.aspx>.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME (Last, First, Middle Initial)		2. SSN	3. DATE OF BIRTH (YYYY/MM/DD)
4a. MAILING ADDRESS (Include ZIP Code)		b. HOME TELEPHONE NO. ()	
		5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN
6a. PATIENT'S EMPLOYER'S NAME		b. EMPLOYER TELEPHONE NUMBER	

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

a. YES. (If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)

(1) Member ID	(2) Plan ID	(3) Expiration Date (YYYY/MM/DD)
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(4) VA Facility Name (e.g., primary care/specialty clinic) that assists in coordinating your care

(5) VA Facility Address and Telephone Number

()

b. NO. (Proceed to Item 8.)

8. DO YOU HAVE OTHER HEALTH INSURANCE? (This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)

a. YES. (Complete Item 9 and the remaining sections below.)

b. NO, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. (Proceed to Item 13.)

c. NO, but I am not a DoD beneficiary. (Proceed to Item 12.)

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER (Last, First, Middle Initial)		b. DATE OF BIRTH (YYYY/MM/DD)	c. RELATIONSHIP TO POLICY HOLDER
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER		e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE (YYYY/MM/DD)	m. POLICY END DATE (YYYY/MM/DD)

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number
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10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.									
a. NAME OF POLICY HOLDER (<i>Last, First, Middle Initial</i>)				b. DATE OF BIRTH (<i>YYYY/MM/DD</i>)		c. RELATIONSHIP TO POLICY HOLDER			
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER									
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER									
f. CARD HOLDER ID		g. POLICY ID		h. GROUP POLICY ID		i. GROUP PLAN NAME			
j. ENROLLMENT/PLAN CODE		k. INSURANCE TYPE		l. POLICY EFFECTIVE DATE (<i>YYYY/MM/DD</i>)		m. POLICY END DATE (<i>YYYY/MM/DD</i>)			
n. (1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number									
(2) Rx Policy ID			(3) Rx Bin Number			(4) Rx PCN Number			
11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?									
a. YES (<i>Complete 11c.-f. and proceed to Item 13.</i>)				b. NO (<i>Proceed to Item 13.</i>)					
c. NAME (<i>Last, First, Middle Initial</i>)		d. SSN	e. DATE OF BIRTH (<i>YYYY/MM/DD</i>)	f. RELATIONSHIP TO POLICY HOLDER	c. NAME (<i>Last, First, Middle Initial</i>)		d. SSN	e. DATE OF BIRTH (<i>YYYY/MM/DD</i>)	f. RELATIONSHIP TO POLICY HOLDER
12. MEDICARE OR MEDICAID INFORMATION									
a. MEDICARE PART A NUMBER		b. MEDICARE PART B NUMBER		c. MEDICARE MANAGED CARE PLAN NAME					
d. MEDICARE PART D NUMBER AND PLAN NAME				e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE					
13. CERTIFICATION, RELEASE, AND ASSIGNMENT									
a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of \$250,000 or imprisonment for five years, or both.									
b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.									
c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.									
d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.									
e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.									
f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.									
14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE						b. DATE (<i>YYYY/MM/DD</i>)			
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE						b. DATE (<i>YYYY/MM/DD</i>)			
16. ANNUAL PATIENT INSURANCE VERIFICATION									
a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.									
b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.									
17a. SIGNATURE (<i>Patient or Adult Family Member</i>)						b. DATE (<i>YYYY/MM/DD</i>)			
18. VERIFICATION		(2) Initials	b.(1) Date (<i>YYYY/MM/DD</i>)	(2) Initials	c.(1) Date (<i>YYYY/MM/DD</i>)	(2) Initials			
a. (1) Date (<i>YYYY/MM/DD</i>)									



DEFENSE HEALTH AGENCY NATIONAL CAPITAL REGION Pre-Surgical/Pre-Procedural Instructions

Surgery Date:

Surgeon(s):

Location:

Fort Belvoir Community Hospital

9300 DeWitt Loop
Fort Belvoir, VA 22060
Main: (571) 231-4185
APU check-in: Oaks Pavilion, 2nd Floor

Kimbrough Ambulatory Care Center

2480 Llewellyn Avenue
Fort Meade, MD 20755
Main: (301) 677-8800
Same Day Surgery: 1st Floor, East Wing

Malcolm Grow Medical Clinic 1060

W. Perimeter Road
Joint Base Andrews, MD 20762
Main: (240) 612-4866/1152/1031
Same Day Surgery: 2nd Floor, East Wing

Walter Reed National Mil Med Center

4494 North Palmer Road
Bethesda, MD 20889
Main: (301) 295-4611
APU Surgery Check-in: Building 10, 3rd Floor

PATIENT RESPONSIBILITIES PRIOR TO SURGERY:

- 1. Have a responsible adult (≥18 years) to take you home and stay the night after being discharged.** Your escort must stay in the hospital/facility at all times. If you cannot make these arrangements, contact your surgeon before your surgery date to be rescheduled. Visitors will wait in the family lounge area during your surgery and will be notified by the hospital staff when they can see you during the post-operative care. Note that Taxi cabs and Rideshare Apps (Uber/Lyft) are NOT acceptable and surgery may be cancelled if no responsible adult is available.
- 2. Complete all ordered labs, EKGs, x-rays, and diagnostic tests prior to your surgery/procedure time (as needed).**
- 3. Adhere to your medication regimen as outlined by your surgeon or modified by anesthesia staff. Take all regularly scheduled medications with a sip of water the morning of surgery unless otherwise instructed by anesthesia/surgeon.**
 - DO NOT take aspirin-containing medications, or Ibuprofen/Motrin/Advil/Naproxen/Aleve type medications, including over-the-counter, for ___ days prior to and ___ days after your surgery.
 - DO NOT take herbal/dietary supplements (e.g. workout supplements, ginkgo biloba, garlic, ginger, fish oil, omega-3, or vitamin E, etc.), herbal teas, and diet supplements 2 weeks prior to surgery.
 - Patients who have had heart stents or heart conditions, consult your cardiologist before stopping any medication.
- 4. If you were not scheduled to be seen for an APU Prescreen appointment, you will be contacted by a perioperative staff member for a telephone consultation within 72 hours prior to your surgery date.**
- 5. If you wish to cancel your procedure, or if you develop a fever, rash, cold, sore throat, or other illness between now and your surgery date, contact your surgeon in their respective clinic. If after hours, please contact the main hospital number to have the surgeon on call paged to speak to you.**
- 6. Complete all pre-op preparations as instructed by your surgical clinic. This includes bowel and skin prep, if applicable.**
- 7. If you are a smoker, please talk to your primary care about smoking cessation. Please refrain from smoking 24 hours prior to surgery. Please call 1-800-QUIT-NOW (784-8669) for assistance and refer to our smoking cessation materials.**

Patient Name (Last, First):

DOD ID Number:

Date of Birth:

THE BUSINESS DAY PRIOR TO YOUR SURGERY/PROCEDURE: (date) _____ CALL FOR REPORT/ARRIVAL TIME:

Arrival times are determined by the main operating room, not the surgeon. Please do not come any earlier than your scheduled arrival time.

Fort Belvoir Community Hospital
(571) 231-4503
2:30 pm – 4:30 pm (1430-1630)

Kimbrough Ambulatory Care Center
(301) 677-8020 or (301) 677-8019
1:00 pm – 4:00 pm (1300-1600)

Malcolm Grow Medical Clinic
(240) 612-2004 or (240) 612-1957
2:00 pm – 4:00 pm (1400-1600)

Walter Reed National Mil Med Center
(301) 295-2563
1:30 pm – 4:00 pm (1330-1600)

THE EVENING BEFORE YOUR SURGERY/PROCEDURE:

1. Unless otherwise directed, **DO NOT EAT ANYTHING AFTER MIDNIGHT** on the night before your procedure. This includes coffee, tea, toast, candy, or gum. Clear liquids (excluding alcohol) may be ingested for up to 2 hours before arrival time.
2. Do not consume any **alcohol** or use **tobacco** products 24 hours prior to your procedure.

THE DAY OF THE SURGERY/PROCEDURE:

1. **Bring with you** to the hospital:
 - Military or Government-issued ID card
 - “Pre-op Check” sticker sheet (if required to perform surgical skin wipes from surgeon)
 - Crutches, walkers, canes, or wheelchairs if required
 - CPAP machine if required
 - Any inhalers, if prescribed. Otherwise, please do not bring home medications.
 - Copy of Advanced Directive, Living Will, 5 Wishes, or Power of attorney (if applicable)
2. If instructed to take any medications by mouth on the morning of your procedure, do so with a small sip of plain water.
3. **For children less than 13 years old only:**
 - No solid food after midnight the evening prior to the procedure.
 - Clear liquids up to two hours prior to arrival time.
 - Breast milk up to four hours prior to arrival time.
 - Infant formula up to six hours prior to arrival time.
 - All non-human milk up to six hours prior to arrival time.
 - You may bring pajamas, a favorite blanket, and/or a favorite toy to comfort them.
4. You may shower and brush your teeth with **sips** of water.
5. Wear comfortable, loose-fitting clothes and preferably a button-down shirt. You may have bulky dressings placed during surgery. Wear comfortable shoes.
6. **DO NOT wear** makeup, nail polish, or contact lenses. Remove all removable metal objects from your body and hair. All piercings, adornments, dentures, hearing aids, contact lenses, and glasses must be removed prior to going to the OR. Do not apply lotion, perfume, cologne, scented deodorant, or powder after showering. Do not shave area of surgery.

AFTER SURGERY:

1. Anesthesia effects may linger. For the first 24 hours after surgery, **DO NOT** drive, operate hazardous machinery or power tools, drink alcohol, take any medications other than prescribed, or make legal decisions.
2. Remain quietly at home for the day and rest. Arrange for someone to care for your small children for the day.
3. Take liquids first and slowly progress to a light meal.
4. If you are staying overnight for observation, you will be discharged by 0800 the next morning.

Staff Name _____ Staff Signature _____ Date _____
Patient Name _____ Patient Signature _____ Date _____