IN THE COURT OF APPEALS OF THE STATE OF NEVADA

VENETIAN CASINO RESORT, LLC; AND LAS VEGAS SANDS, LLC,

Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK; AND THE HONORABLE KATHLEEN E. DELANEY, DISTRICT JUDGE,

Respondents,

and

JOYCE SEKERA, AN INDIVIDUAL,

Real Party in Interest.

No. 83600-COA

REAL PARTY IN INTEREST'S APPENDIX, VOLUME 3 (Nos. 460–703)

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Attorneys for Real Party in Interest, Joyce Sekera

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Transcript of April 22, 2019 Deposition of Milan Graovac	Vol. 8, 1524–1572
Plaintiff Joyce Sekera's Sixth Supplemental Early Case Conference Disclosure Statement, List of Documents and Witnesses, and NRCP 16.1(a)(3) Pre-Trial Disclosure (served 06/17/2019)	Vol. 8, 1573–1586
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Plaintiff Joyce Sekera's Fourteenth Supplemental Early Case Conference Disclosure Statement, List of Documents and Witnesses, and NRCP 16.1(a)(3) Pre-Trial Disclosure (served 09/03/2019)	Vol. 9, 1760–1778
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RECEIVED 12/22/2016 11:51AM 7024639772 DR. JORDAN WEBBER
12/22/2016 10:48 SDMI-FP1 SDMI-FP1-4 D 1/2

STEINBERG DIAGNOSTIC MEDICAL IMAGING CENTERS

Phone: (702) 732-6000 www.sdmi-lv.com Fax: (702) 732-6071

Patient Name: Joyce P Sekera

Patient: **Joyce P Sekera**	Physician: **Jordan Webber DC**
SDMI #: **790179.0**	Dr. Fax: **(702) 463-9772**
Pt. DOB: **03/22/1956**	Dr. Phone: **(702) 463-9508**
Pt. Sex: **Female**	Dr. Addr.: **7810 W Ann Rd Ste 110 Las Vegas, NV 89149**
Date of Service: **12/21/16**	Cc:
SDMI Location: **CH**	Cc:

MRI CERVICAL SPINE WITHOUT CONTRAST

CLINICAL HISTORY:

Neck pain and bilateral arm numbness, pain, weakness

TECHNIQUE:

T1 sagittal, T2 sagittal and axial T2 images were obtained. 117 images.

COMPARISON:

None

FINDINGS:

There is mild dextrocurvature centered at C6-7. There is straightening of the cervical lordosis. Vertebral bodies are normal in alignment. Vertebral body heights are maintained. Bone marrow signal is normal. Spinal cord is normal in signal. The paravertebral soft tissues appear unremarkable. The intervertebral discs throughout the cervical spine are desiccated without significant loss of height.

C2-3: No disc bulge, spinal canal or neuroforaminal stenosis.

C3-4: No disc bulge, spinal canal or neuroforaminal stenosis. Mild bilateral facet hypertrophy.

C4-5: No disc bulge, spinal canal or neuroforaminal stenosis. Mild left uncovertebral arthropathy. Mild bilateral facet hypertrophy.

C5-6: Mild broad disc protrusion. Spinal canal AP diameter of 12 mm. Bilateral facet hypertrophy. Bilateral uncovertebral arthropathy. Mild left greater than right neuroforaminal stenosis.

C6-7: Mild broad disc protrusion. Spinal canal AP diameter of 10 mm. No significant neuroforaminal stenosis.

C7-T1: No disc bulge, spinal canal or neuroforaminal stenosis.

IMPRESSION:

Mild multilevel degeneration. Mild neuroforaminal stenosis at C5-C6. No spinal canal stenosis throughout. Mild dextrocurvature. Straightening of the cervical lordosis which may be seen with muscle spasm.

12/22/16 JW

JS433

STEINBERG DIAGNOSTIC MEDICAL IMAGING CENTERS

Phone: (702) 732-6000 www.sdmi-lv.com Fax: (702) 732-6071

Patient Name: Joyce P Sekera

Interpreted by: Sarah Kym MD 12/22/2016 8:20 AM

Electronically approved by: Sarah Kym MD Date: 12/22/16 10:47

JS434

RECEIVED 11/30/2016 03:1[illegible] 7024639772 DR. JORDAN WEBBER
To: WEBBER DC, JORDAN Fr[illegible] Las Vegas Radiology

LAS VEGAS RADIOLOGY

TOMORROW'S RADIOLOGY IMAGING... TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
8530 W. Sunset Rd, Suite 120, Las Vegas, Nevada 89113
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109

Tel:(702) 254-5004 / Fax:(702) 432-4005

Patient:	SEKERA, JOYCE	**Date of Service:**	11/30/2016
DOB:	3/22/1956	**Age/Sex:**	60 / F
MR#:	1907994	**Accession #:**	LVR-136396

Referring Physician: JORDAN WEBBER DC

PROCEDURE: XRAY Left HIP UNILATERAL 2 VIEW

COMPARISON: None.

INDICATIONS: LEFT HIP PAIN

FINDINGS:

BONES:	Skin fold artifacts overlie the proximal aspect of each femur. There is mild osteophyte formation at each acetabulofemoral joint. There is a soft tissue calcification or prior avulsion fracture adjacent to the right acetabulum
SOFT TISSUES:	Negative. No visible soft tissue swelling.
EFFUSION:	None visible.
OTHER:	Negative.

CONCLUSION:

1. **Mild arthropathy of each hip.**
2. **If symptoms persist, additional imaging of the hip should be considered**

Dictated by: Elizabeth L Huck, D.O. on 11/30/2016 at 14:09
Approved by: Elizabeth L Huck, D.O. on 11/30/2016 at 14:17

11/30/16
JW

JS435

RECEIVED 11/30/2016 03:20PM 7024639772 DR. JORDAN WEBBER
To: WEBBER DC, JORDAN FT Las Vegas Radiology

LAS VEGAS RADIOLOGY

TOMORROW'S RADIOLOGY IMAGING... TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
8530 W. Sunset Rd, Suite 120, Las Vegas, Nevada 89113
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109

Tel:(702) 254-5004 / Fax:(702) 432-4005

Patient:	SEKERA, JOYCE	**Date of Service:**	11/30/2016
DOB:	3/22/1956	**Age/Sex:**	60 / F
MR#:	1907994	**Accession #:**	LVR-136397

Referring Physician: JORDAN WEBBER DC

PROCEDURE: XRAY SI JOINTS 2 VIEW

COMPARISON: None.

INDICATIONS: LEFT SACROILLIAC JOINT PAIN

FINDINGS:

BONES:	There is mild marginal sclerosis at the sacroiliac joint.
SOFT TISSUES:	Negative. No visible soft tissue swelling.
EFFUSION:	None visible.
OTHER:	Negative.

CONCLUSION:

1. **Mild arthropathy of each sacroiliac joint. If symptoms persist additional imaging should be considered**

Dictated by: Elizabeth L Huck, D.O. on 11/30/2016 at 14:11
Approved by: Elizabeth L Huck, D.O. on 11/30/2016 at 14:17

11/30/16 JW

JS436

RECEIVED 11/14/2016 06:09PM 7024639772 DR. JORDAN WEBBER
To: WEBBER DC, JORDAN Fr Las Vegas Radiology

LAS VEGAS RADIOLOGY

Tel:(702) 254-5004 / Fax:(702) 432-4005

TOMORROW'S RADIOLOGY IMAGING... TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
8530 W. Sunset Rd, Suite 120, Las Vegas, Nevada 89113
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109

Patient:	SEKERA, JOYCE	**Date of Service:**	11/14/2016
DOB:	3/22/1956	**Age/Sex:**	60 / F
MR#:	1907994	**Accession #:**	LVR-133268

Referring Physician: JORDAN WEBBER DC

PROCEDURE: XRAY THORACIC SPINE 2 VIEW

COMPARISON: None.

INDICATIONS: UPPER BACK PAIN

FINDINGS:
No measurable degree of scoliosis. No paraspinal soft tissue mass. Multilevel vertebral body endplate changes and osteophyte formation. No compression fracture or spondylolisthesis

CONCLUSION:
1. **No evidence of acute skeletal pathology to the thoracic spine**

Dictated by: James D. Balodimas, M.D. on 11/14/2016 at 17:06
Approved by: James D. Balodimas, M.D. on 11/14/2016 at 17:07

11/14/16 JD

JS437

LAS VEGAS RADIOLOGY

TOMORROW'S RADIOLOGY IMAGING... TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
8530 W. Sunset Rd, Suite 120, Las Vegas, Nevada 89113
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109

Tel:(702) 254-5004 / Fax:(702) 432-4005

Patient:	SEKERA, JOYCE	**Date of Service:**	11/14/2016
DOB:	3/22/1956	**Age/Sex:**	60 / F
MR#:	1907994	**Accession #:**	LVR-133269

Referring Physician: JORDAN WEBBER DC

PROCEDURE: XRAY L SHOULDER 2 VIEW

COMPARISON: None.

INDICATIONS: LEFT SHOULDER PAIN

FINDINGS:
There is no evidence of acute fracture or dislocation. No erosive arthropathy.

CONCLUSION:
1. **No evidence of acute skeletal pathology to the left shoulder. There are mild degenerative changes at the acromioclavicular articulation.**

Dictated by: James D. Balodimas, M.D. on 11/14/2016 at 16:57
Approved by: James D. Balodimas, M.D. on 11/14/2016 at 16:59

11/14/16 JW

JS438

LAS VEGAS RADIOLOGY

TOMORROW'S RADIOLOGY IMAGING... TODAY
7500 Smoke Ranch Road, Suite 100, Las Vegas, Nevada 89128
8530 W. Sunset Rd, Suite 120, Las Vegas, Nevada 89113
3201 S. Maryland Pkwy, Suite 102, Las Vegas, Nevada 89109

Tel:(702) 254-5006 / Fax:(702) 432-4805

Patient:	SEKERA, JOYCE	**Date of Service:**	11/14/2016
DOB:	3/22/1956	**Age/Sex:**	60 / F
MR#:	1907994	**Accession #:**	LVR-133267

Referring Physician: JORDAN WEBBER DC

PROCEDURE: XRAY CERVICAL SPINE W/ FLEX EXTENSION

COMPARISON: None.

INDICATIONS: NECK PAIN

FINDINGS:
BONES: The odontoid process is intact. There is no prevertebral soft tissue swelling. There are levels which demonstrate mild osteophyte formation. No significant degree of spondylolisthesis.
DISC SPACES: Unremarkable for age
PARASPINOUS: No evidence of paraspinous soft tissue mass.
CONCLUSION:
1. **No evidence of acute fracture. No significant spondylolisthesis. On the neutral, lateral projection, there is reversal of the normal lordotic curvature, could be due to spasm.**

Dictated by: James D. Balodimas, M.D. on 11/14/2016 at 16:53
Approved by: James D. Balodimas, M.D. on 11/14/2016 at 16:57

11/14/16 JS

JS439

RECEIVED 11/08/2016 05:46PM 7024639772 DR. JORDAN WEBBER
Nov. 8. 2016 5:01PM No. 7270 P. 7/8

CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE Admit: 11/4/2016
MRN: CHH7120336 Disch: 11/4/2016
DOB/Sex: 3/22/1956 / Female FIN: CHH0008005149375
Attending: ED,Staff Physician

Imaging

PROCEDURE	EXAM DATE/TIME	ACCESSION	PATIENT AGE AT EXAM	ORDERING PROVIDER	STATUS
XR Spine Lumbosacral 2 or 3 Views	11/4/2016 16:35 PDT	40-XR-16-040537	60 years	Taylor,Rachael APRN	Auth (Verified)

Report
XR LUMBAR SPINE

HISTORY: Back pain

COMPARISON: None.

TECHNIQUE: Lumbar spine, 3 views.

FINDINGS: There is no more lumbar vertebral body height. Endplate osteophyte formation at L2-3. No acute fracture deformity. No aggressive lytic sclerotic lesions. Moderate stool. Mild curvature convex to the left. Some increased density at the L2-3 disk osteophyte to some calcification. There are some endplate degenerative change at L1-2 also noted.

IMPRESSION:

Degenerative disk disease most conspicuously at L2-3 where there is endplate osteophyte formation and some endplate sclerosis.. There is slight increased density at the disk space of uncertain etiology possibly related to some calcification. Further assessment with CT or MRI scan can be obtained as clinically warranted.

Dictated By: KAVEH KARDOONI DO
***** *Final* *****

Dictated by: Kardooni, Kaveh DO Dictated DT/TM: 11/04/2016 4:52 pm
Transcribed By: KKTranscribed by: KK Transcribed DT/TM: 11/04/16 16:49:51
Electronically Signed by: Kardooni, Kaveh DO Signed DT/TM: 11/04/2016 4:52 pm

PROCEDURE	EXAM DATE/TIME	ACCESSION	PATIENT AGE AT EXAM	ORDERING PROVIDER	STATUS
XR Elbow Complete Left	11/4/2016 16:35 PDT	40-XR-16-040539	60 years	Taylor,Rachael APRN	Auth (Verified)

Report
XR ELBOW

HISTORY: Injury to elbow

COMPARISON: None.

TECHNIQUE: Left , 4 views.

JS440

RECEIVED 11/08/2016 05:46PM 7024639772 DR. JORDAN WEBBER
Nov. 8. 2016 5:01PM No. 7270 P. 8/8

CHH- Centennial Hills Hospital Medical Center

Patient: SEKERA, JOYCE
MRN: CHH7120336
DOB/Sex: 3/22/1956 / Female
Attending: ED,Staff Physician

Admit: 11/4/2016
Disch: 11/4/2016
FIN: CHH0008005149375

Imaging

PROCEDURE	EXAM DATE/TIME	ACCESSION	PATIENT AGE AT EXAM	ORDERING PROVIDER	STATUS
XR Elbow Complete Left	11/4/2016 16:35 PDT	40-XR-16-040539	60 years	Taylor,Rachael APRN	Auth (Verified)

Report

FINDINGS:

There is no evidence of fracture. There is no evidence of dislocation or subluxation. Bone mineralization is normal. The articular surfaces and joint spaces are well preserved. There are no osseous lesions. There are no soft tissue abnormalities.

IMPRESSION:

No evidence of acute fracture or dislocation.

Please note that some abnormalities may not be able to be detected with radiographs. If clinical symptoms persist, consider cross sectional imaging.

Dictated By: RICK YEH MD

***** *Final* *****

Dictated by: *Yeh MD, Rick N* *Dictated DT/TM:* *11/04/2016 4:44 pm*
Transcribed By: *RNYTranscribed by:* *RNY* *Transcribed DT/TM:* *11/04/16 16:42:39*
Electronically Signed by: *Yeh MD, Rick N* *Signed DT/TM:* *11/04/2016 4:44 pm*

PAIN INSTITUTE OF NEVADA

Pain Institute of Nevada
7435 W Azure Dr., Suite 190, Las Vegas, NV 89130
(702) 878-8252 (phone) (702) 628-5098 (fax)

Walter M. Kidwell, M.D.
Katherine D. Travnicek, M.D.
Gregory Jarrett, D.C.
Gina M. Nguyen, PA-C

PATIENT REGISTRATION FORM

Patient Information:

Last Name: SEKERA First Name: Joyce MI: P
Address: 7840 Nesting Pine Pl
City: Las Vegas State: NV Zip Code: 89143
Home Phone: — Cell: 702-467-5457 Work: ____
E-Mail: ____

Date of Birth: 3-22-56 SSN#: 091-48-8430
Driver's Lic#: 2000 75 7876 State Issued: NV

Gender: Male___ Female ✓
Marital Status: Single ✓ Married___ Divorced____ Widow____

Employer Name: Brand Vegas
Employer Address: 3130 S. Rainbow

Emergency Contact Information:
Name: Marissa Freeman
Relationship: Daughter
Contact Phone: 1. 702 525 900 (2. ____

The Following Information is REQUIRED by the Federal Government:

Race: white
Ethnicity: ____
Preferred Language: English
Preferred Communication: Cell Phone

Pain Institute of Nevada
7435 W Azure Dr., Ste. 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9098
www.paininstitute.com

Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

Pain Scale
0 /10: No Pain
1 /10: Minimal pain
2 /10: Mild pain, No impact on daily activities
3 /10: Mild pain, Minimal impact of daily activities
4 /10: Moderate pain, Minimal limitations of daily activities
5 /10: Moderate pain, Some limitations of daily activities
6 /10: Moderate pain, Moderate limitations of daily activities
7 /10: Moderate/Severe pain, Very limited daily activities
8 /10: Moderate/Severe pain, Very difficult to perform daily activities
9 /10: Severe Pain, Severely limited ability to perform daily activities
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

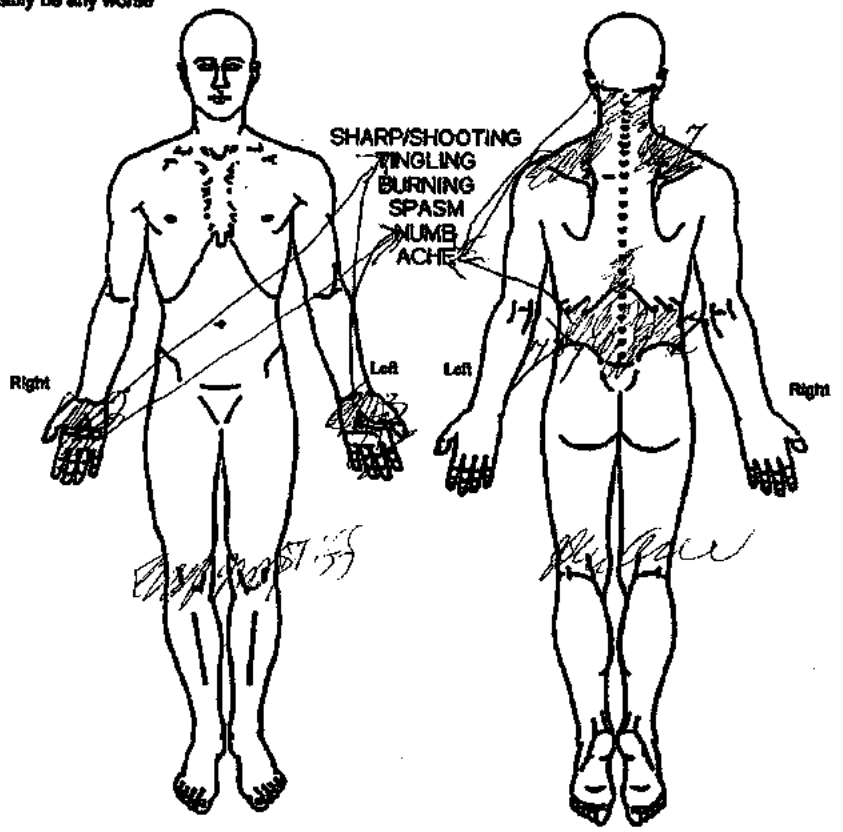
How far can you walk? _____

How long can you sit? _____

How long can you stand? 10min

Are you working? NO

Are you able to work? NO



Name: Joyce DeKeyser

Date: 1-9-17

Revised February 24, 2016

JS443

Insurance Information:

Primary Insurance: LAWYER

Primary Insurance Holder: (if other than patient):

Member ID#: **Group #:**

Home Phone: Cell: Work:

Date of Birth: SSN#:

Driver's Lic#: State Issued:

Employer Name:

Employer Address:

Secondary Insurance:

Secondary Insurance Holder: (If other than patient):

Member ID#: **Group #:**

Home Phone: Cell: Work:

Date of Birth: SSN#:

Driver's Lic#: State Issued:

Employer Name:

Employer Address:

Is this treatment for a personal injury claim? Yes NOT No ✓ If no skip this section.

Is this treatment for a motor vehicle claim? Yes___ No___ If no skip this section.

Date of Injury: ~~11-4-16~~ State Injury occurred in: NV

Med Pay Ins Carrier: Adjuster's Name:

Claim #:

Do you have an attorney: Yes ✓ No___ If no skip this section.

Attorney Name: Keith Galliher Phone #: 702 735 0049

Attorney Address: 1850 E. SAHARA

City: LAS VEGAS State: NV Zip Code:

Is this treatment for a work related injury? Yes ✓ No___ If no skip this section.

Date of Injury: 11-4-16 State Injury occurred in: NV

Ins Carrier: Adjuster's Name:

Claim#: Claim Status:

HIPAA Information:

Consent for Use and Disclosure of Protected Health Information

HIPAA refers to federal laws that regulate disclosures of PHI (protected health information). You have the right to request restriction on how your PHI is used and communicated in order to protect your privacy. This authorization allows for the release of PHI pursuant to 45CFR parts 160 and 164.

Protected Health Information is routinely disclosed to the following entities:
*To your insurance company for authorization or so we can obtain payment
*To the physician that referred you to us
*To a physician or medical entity we may refer you to.

Right to Revoke, Terminate, or Modify: You may revoke, terminate or modify tis authorization by submitting a written request to the Privacy Officer at the Pain Institute of Nevada.

Important Note: If we are restricted from disclosing your PHI to your insurance company you may be personally responsible for payment.

I wish to be contacted in the following manner: (check all that apply)

HOME phone: Yes ___ No ✓
Ok to leave detailed message: Yes___ No___ Leave call back number ONLY: Yes___ No____

CELL phone: Yes ✓ No ___
Ok to leave detailed message: Yes ✓ No___ Leave call back number ONLY: Yes___ No____

WORK phone: Yes ___ No ___
Ok to leave detailed message: Yes___ No___ Leave call back number ONLY: Yes___ No____

I authorize the following person(s) or entities to receive my Protect Health Information:
Check all that apply:
Spouse ___. Name: _____ Partner___ Name: _____
Parent ✓ Name: Carole DiVito Child: ✓ Name: Marissa Freeman
Attorney ✓ Name: Keith Galliher Insurance___ Name: _____
Other: _____
Other Instructions: _____

Patient Signature

Name of person signing for patient and by what authority

Billing Information, Clinic Policies, and Consent for Treatment

- The Pain Institute of Nevada will be your primary insurance only as a courtesy to you. You are ultimately responsible for payment.
- Secondary insurance will not be billed except for specific procedures. All co-pays are due at or before the time of service.
- If no payment is received from your insurance after 45 days then the payment burden falls to you.
- Interest will accrue at 18% annually for bills over 90 days overdue – Any and all collection fees will be applied to collection accounts.
- Missed appointments will be assessed a $50.00 fee. This includes appointments not cancelled within 24 hours of the scheduled time.
- You need to notify us immediately of any change of address, phone number, insurance or attorney.
- Failure to notify us of insurance or attorney change may result in you being responsible for your entire bill.
- All co-pays, deductibles and cash payments are due at the time of service.
- We accept Visa, MasterCard, American Express, Discover, Checks and Cash. Returned checks are assessed a $25.00 fee.
- Attorney liens are accepted on a case by case basis.
- If you are treated under alien, we will not go back and bill insurance at a later time. You are ultimately responsible for the bill.
- All appointments are by appointment only. Walk-ins are not accepted. No exceptions.
- We do not overbook. Please be on time for your appointment. If you are late we will attempt to work you in, but, we will see the on-time patient's first.
- All prescriptions are written during your appointment in the office. We do not call in prescriptions.
- Prescriptions are not written at the surgery centers during procedures. Prescriptions may be obtained only during scheduled office appointments.
- All medication prescriptions are in accordance with state and federal law.
- Random drug screening is performed by this clinic to monitor compliance.
- Patients have the right to refuse any prescribed treatment. However, we have the right to refuse to treat any patient due to non-compliance.
- It is against the law to share, sell or distribute medications.
- It is against the law to obtain controlled substances from multiple physicians without notifying the physicians in question.
- It is against the law to forge prescriptions.
- Any patient engaging in above noted illegal activities will be discharged from the practice and turned over to law enforcement.

I acknowledge that I have read the polices noted and agree to comply.
I authorize the Pain Institute of Nevada to endorse any checks made payable to me as a result of the treatment I receive.
I consent to treatment as directed by the physicians and physician extenders of the Pain Institute of Nevada.
I request the following insurance company or attorney be billed for my treatment. _____

Patient or legal guardian signature

1-9-17
Date

Revised February 24, 2016

JS446

Lab Results for SekEra, Joyce (Female, 03/22/1956)

practice fusion
Free cloud based EHR

Laboratory

Collection: 04/20/2017 08:52 am
Order #: 01681510
Accession #: 01681510

Name: Quest Diagnostics

Patient information

Patient ID: SJ611501
Mobile: 7024675457
Address: 7840 Nesting Pine Pl
Las Vegas, NV 89143

Requesting Provider

Name: Donald McGrorey

Attachments

attachment1
attachment1
attachment1
attachment1

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
Glucose, Fasting [1]	98	65-99 mg/dL	04/22/2017 12:44 am
BUN [1]	10	7-25 mg/dL	04/22/2017 12:44 am
Creatinine [1]	0.53	0.50-0.99 mg/dL	04/22/2017 12:44 am
BUN/Creatinine Ratio [1]	18.9	6.0-22.0 calc	04/22/2017 12:44 am
Calcium [1]	8.9	8.6-10.4 mg/dL	04/22/2017 12:44 am
Protein, Total [1]	6.7	6.1-8.1 g/dL	04/22/2017 12:44 am
Albumin [1]	4.0	3.6-5.1 g/dL	04/22/2017 12:44 am
Globulin [1]	2.7	1.9-3.7 g/dL	04/22/2017 12:44 am
A/G Ratio [1]	1.5	1.0-2.5 calc	04/22/2017 12:44 am
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	04/22/2017 12:44 am
Alkaline Phosphatase [1]	85	33-130 IU/L	04/22/2017 12:44 am
AST (SGOT) [1]	20	10-35 IU/L	04/22/2017 12:44 am
ALT (SGPT) [1]	29	6-29 IU/L	04/22/2017 12:44 am
Sodium [1]	139	135-146 mmol/L	04/22/2017 12:44 am
Potassium [1]	4.1	3.5-5.3 mmol/L	04/22/2017 12:44 am
Chloride [1]	104	98-110 mmol/L	04/22/2017 12:44 am
CO2 [1]	26	20-31 mmol/L	04/22/2017 12:44 am
eGFR African American [1]	119	>59 mL/min/1.73m2	04/22/2017 12:44 am
eGFR Non-AFR. American [1]	102	>59 mL/min/1.73m2	04/22/2017 12:44 am

Vendor note: The upper reference limit for Creatinine is approximately 13% higher for people identified as African-American.
Glucose reference range reflects a fasting state.
For non-fasting patients glucose reference range is 65 - 139 mg/dL.

JS447

LIPID PANEL

Observations	Result	Reference / UoM	Date/Status

CHOLESTEROL [1]	182	125-200 mg/dL	04/22/2017 12:44 am
Triglycerides [1]	93	0-150 mg/dL	04/22/2017 12:44 am
HDL Cholesterol [1]	● 44	46-199 mg/dL Below low normal	04/22/2017 12:44 am
CHOL/HDLC RATIO [1]	4.14	0.0-5.00	04/22/2017 12:44 am
LDL (Calculated) [1]	119	0-130 mg/dL	04/22/2017 12:44 am
Non-HDL Cholesterol [1]	138	0-159 mg/dL	04/22/2017 12:44 am

Vendor note: Desireable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.
Target for non-HDL cholesterol is 30 mg/dL higher than LDL- Cholesterol target.

CBC (H/H, RBC, INDICES, WBC, PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	7.2	3.8-10.8 k/uL	04/22/2017 12:44 am
RBC [1]	4.31	3.80-5.10 Million/uL	04/22/2017 12:44 am
HEMOGLOBIN [1]	13.9	11.7-15.5 g/dL	04/22/2017 12:44 am
HEMATOCRIT [1]	42.2	35.0-45.0 %	04/22/2017 12:44 am
MCV [1]	98.1	80.0-100.0 fL	04/22/2017 12:44 am
MCH [1]	32.2	27.0-33.0 pg	04/22/2017 12:44 am
MCHC [1]	32.9	32.0-36.0 g/dL	04/22/2017 12:44 am
RED CELL DISTRIBUTION [1]	13.7	11.0-15.0 %	04/22/2017 12:44 am
PLATELET COUNT [1]	225	140-400 k/uL	04/22/2017 12:44 am
MEAN PLATELET VOLUME [1]	8.0	7.5-12.5 fL	04/22/2017 12:44 am

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
Hemoglobin A1c [1]	● 6.5	0.0-5.6 %T.Hgb Above high normal	04/22/2017 12:44 am

Vendor note: For someone without known diabetes, a hemoglobin A1C value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.
For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1C targets should be individualized based on duration of diabetes, age, co-morbid conditions, and other considerations.
Currently, no consensus exists for use of hemoglobin A1C for diagnosis of diabetes for children.

TSH

Observations	Result	Reference / UoM	Date/Status
TSH [1]	1.08	0.40-4.50 mIU/L	04/22/2017 12:44 am

Vendor note:
****
PATIENT COMMENTS:
DR DONALD MCGROREY
PATIENT FASTING.

JS448

Order #01681510

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			04/20/2017 08:52 am

Performing Laboratory
[1] Quest Diagnostics-Elizabeth D. Iole, M.D. 4230 Burnham Ave. Las Vegas, NV 89119

JS449

FROM CLIN PATH LABS PH: 512-339-1275

CLINICAL PATHOLOGY LABORATORIES
9200 Wall Street • Austin, Texas 78754
512-873-1600 1-800-633-4757

CAP Accreditation #: 21525-01
CLIA # 45D0505003

64285
UNIVERSITY URGENT CARE
2628 W CHARLESTON BLVD
LAS VEGAS, NV 89102

DOB: 03/22/1956

PATIENT NAME	PATIENT I.D.	ROOM NUMBER	AGE	SEX	PHYSICIAN
SEKERA, JOYCE			60	F	RUSSELL J SHAH,

PAGE	REQUISITION NO.	ACCESSION NO.	ID NO.	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
1	X9789320	UX116178		12/01/16 12:26P	12/01/16	12/03/16	1:25A

TEST	RESULTS (OUT-OF-RANGE / WITHIN RANGE)	UNITS	EXPECTED RANGE
COMPREHENSIVE METABOLIC PANEL			
GLUCOSE	94	MG/DL	70-99
BUN	7	MG/DL	8-23
CREATININE	0.61	MG/DL	0.60-1.30
eGFR AFRICAN AMER.	114	ML/MIN/1.73	>60
eGFR NON-AFRICAN AMER.	99	ML/MIN/1.73	>60
CALC BUN/CREAT	11	RATIO	6-28
SODIUM	139	MEQ/L	133-146
POTASSIUM	4.6	MEQ/L	3.5-5.4
CHLORIDE	102	MEQ/L	95-107
CARBON DIOXIDE	26	MEQ/L	18-29
CALCIUM	9.2	MG/DL	8.5-10.5
PROTEIN, TOTAL	7.0	G/DL	6.1-8.3
ALBUMIN	4.2	G/DL	3.5-5.2
CALC GLOBULIN	2.8	G/DL	1.9-3.7
CALC A/G RATIO	1.5	RATIO	1.0-2.6
BILIRUBIN, TOTAL	0.3	MG/DL	<=1.2
ALKALINE PHOSPHATASE	96	U/L	38-121
AST	21	U/L	9-40
ALT	31	U/L	5-40
CBC W/AUTO DIFF WITH PLATELETS			
WBC	9.1	K/UL	4.0-11.0
RBC	4.63	M/UL	3.80-5.10
HEMOGLOBIN	14.9	G/DL	11.5-15.5
HEMATOCRIT	43.1	%	34.0-45.0
MCV	93.1	fL	80.0-100.0
MCH	32.2	PG	27.0-34.0
MCHC	34.6	G/DL	32.0-35.5
RDW	11.5	%	11.0-15.0
NEUTROPHILS	59.6	%	40.0-74.0
LYMPHOCYTES	29.1	%	19.0-48.0
MONOCYTES	7.2	%	4.0-13.0
EOSINOPHILS	3.4	%	0.0-7.0
BASOPHILS	0.7	%	0.0-2.0
PLATELET COUNT	274	K/UL	130-400
SEDIMENTATION RATE	30	MM/HOUR	0-20
T4 (THYROXINE)	8.0	UG/DL	4.5-12.0

REPORT CONTINUED ON NEXT FORM

JS450

CONTINUED REPORT FROM CLIN PATH LABS PH: 512-339-1275

CLINICAL PATHOLOGY LABORATORIES
9200 Wall Street • Austin, Texas 78754
512-873-1600 1-800-633-4757

CAP Accreditation #: 21525-01
CLIA # 45D0505003

64285
UNIVERSITY URGENT CARE
2628 W CHARLESTON BLVD
LAS VEGAS, NV 89102

DOB: 03/22/1956

PATIENT NAME	PATIENT I.D.	ROOM NUMBER	AGE	SEX	PHYSICIAN
SEKERA,JOYCE			60	F	RUSSELL J SHAH,

PAGE	REQUISITION NO.	ACCESSION NO.	ID NO.	COLLECTION DATE & TIME	LOG-IN DATE	REPORT DATE	& TIME
2	X9789320	UX116178		12/01/16 12:26	12/01/16	12/03/16	1:25A

TEST	RESULTS (OUT-OF-RANGE WITHIN RANGE)	UNITS	EXPECTED RANGE
TSH REFLEX TO FREE T4	1.1	UIU/ML	0.5-4.7
RPR			
RPR WITH REFLEX TITER			
RPR RESULT	NON-REACTIVE		NON-REACTIVE
RPR TITER	NOT INDIC.TITER		NOT INDIC.
ANA (ANTI-NUCLEAR AB) WITH REFLEX TITER			
ANTI-NUCLEAR ANTIBODIES	NEGATIVE		NEGATIVE

****
* ***** EFFECTIVE 11/14/2016 ***** *
* CLINICAL CHEMISTRY PLATFORM CHANGES IN MAIN LABORATORY *
* ARE ASSOCIATED WITH REFERENCE RANGE CHANGES FOR A NUMBER *
* OF IMMUNOASSAY ANALYTES. PLEASE REVIEW REFERENCE INTERVALS *
* CAREFULLY. *
****

UNLESS OTHERWISE INDICATED, ALL TESTING PERFORMED AT
CLINICAL PATHOLOGY LABORATORIES, INC. 9200 WALL ST AUSTIN, TX 78754
LABORATORY DIRECTOR: MARK A. SILBERMAN, M.D.
CLIA NUMBER 45D0505003 CAP ACCREDITATION NO. 21525-01

*** FINAL REPORT ***

JS451

CLINICAL PATHOLOGY LABORATORIES

9200 Wall Street • Austin, Texas 78754
512-873-1600 1-800-633-4757

CAP Accreditation #: 21525-01
CLIA # 45D0505003

PATIENT NAME	PATIENT I.D.	ROOM NUMBER	AGE	SEX	PHYSICIAN

PAGE	REQUISITION NO.	ACCESSION NO.	ID NO.	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE & TIME

12/03/2016 3:25 AM CST

TEST	RESULTS	UNITS	EXPECTED RANGE
Total reports: 1 Originals: 1 Reprints: 0	Batch: 12/03/2016 #00001		

Autodial Group: FXVEG64285

FAX COMPLETE

JS452

CPL

512-873-5055

CLINICAL PATHOLOGY LABORATORIES
9200 Wall Street • Austin, Texas 78754
512-873-1600 1-800-531-4757

CAP Accreditation #: 21525-01
CLIA # 45D0505003

12/03/2016 3:25 AM CST

PATIENT NAME	PATIENT I.D.	ROOM NUMBER	AGE	SEX	PHYSICIAN

PAGE	REQUISITION NO.	ACCESSION NO.	ID. NO.	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE & TIME

TEST	RESULTS (OUT-OF-RANGE / WITHIN RANGE)	UNITS	EXPECTED RANGE

12/6 12/20

JS453

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www.paininstitute.com

Pain Diagram

In regards to your pain in the last week:

- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

Pain Scale

0 /10: No Pain
1 /10: Minimal pain
2 /10: Mild pain, No impact on daily activities
3 /10: Mild pain, Minimal impact of daily activities
4 /10: Moderate pain, Minimal limitations of daily activities
5 /10: Moderate pain, Some limitations of daily activities
6 /10: Moderate pain, Moderate limitations of daily activities
7 /10: Moderate/Severe pain, Very limited daily activities
8 /10: Moderate/Severe pain, Very difficult to perform daily activities
9 /10: Severe Pain, Severely limited ability to perform daily activities
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

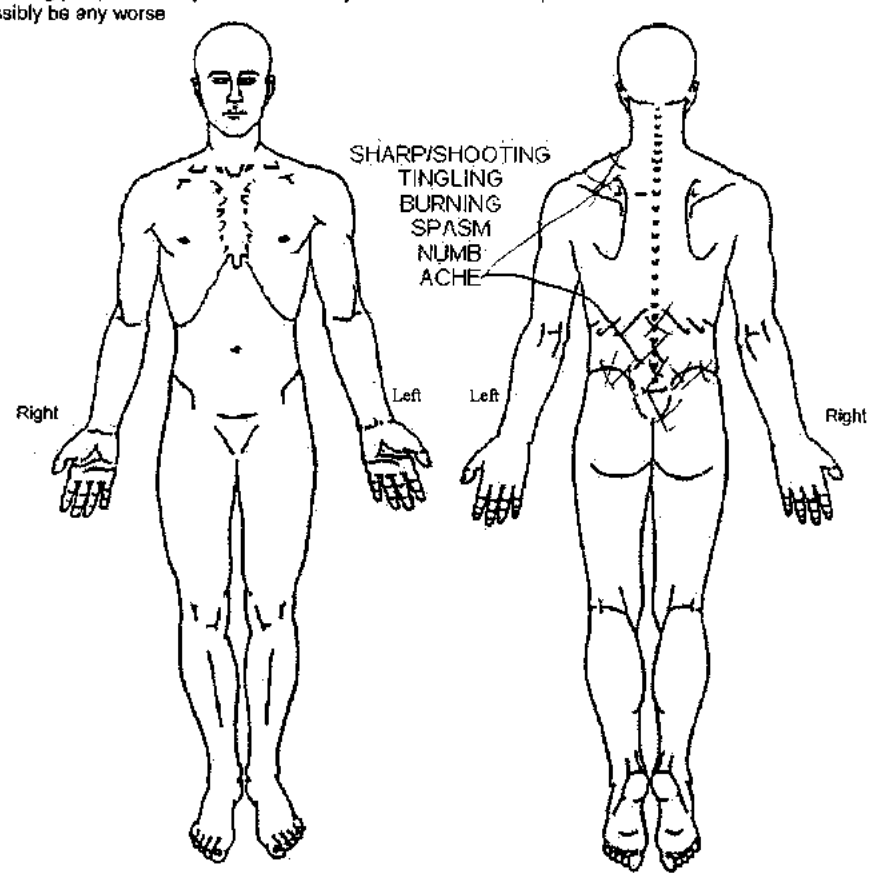
How far can you walk? _____

How long can you sit? _____

How long can you stand? _____

Are you working? _____

Are you able to work? _____



Name: Jayce Sekera

Date: 7-10-17

JS454

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www.paininstitute.com

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Please answer the following questions:

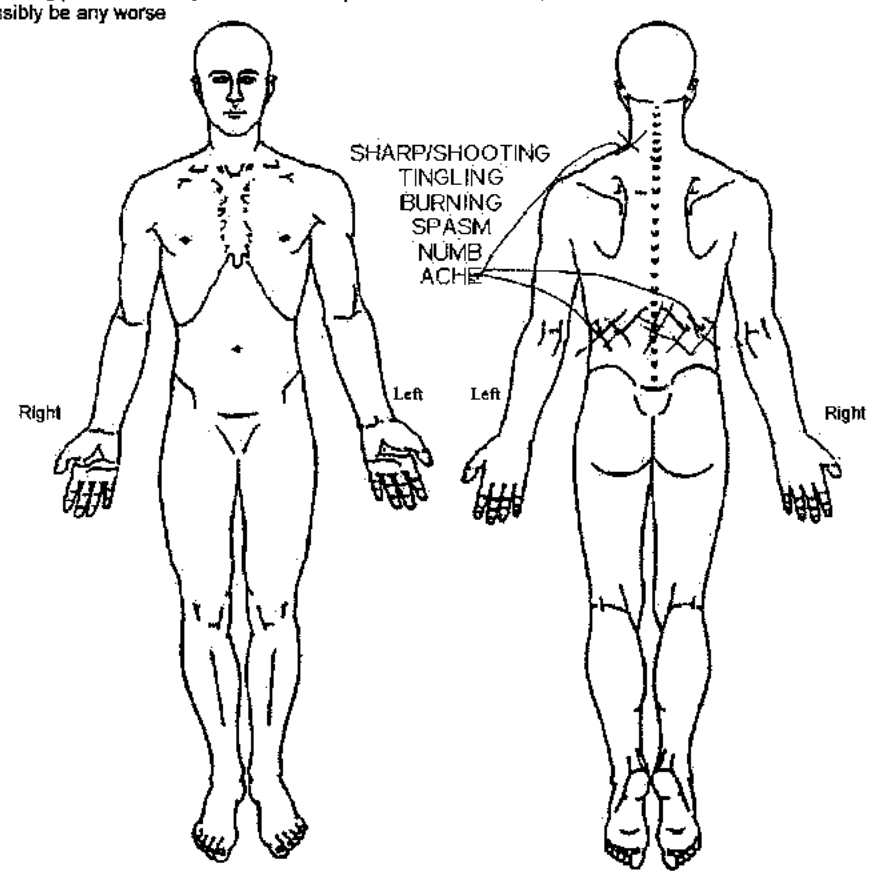
How far can you walk? 10 min

How long can you sit? 10 min

How long can you stand? 10 min

Are you working? N/A

Are you able to work? No



Name: Joyce Sokol

Date: 6-26-17

JS455

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www paininstitute.com

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10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

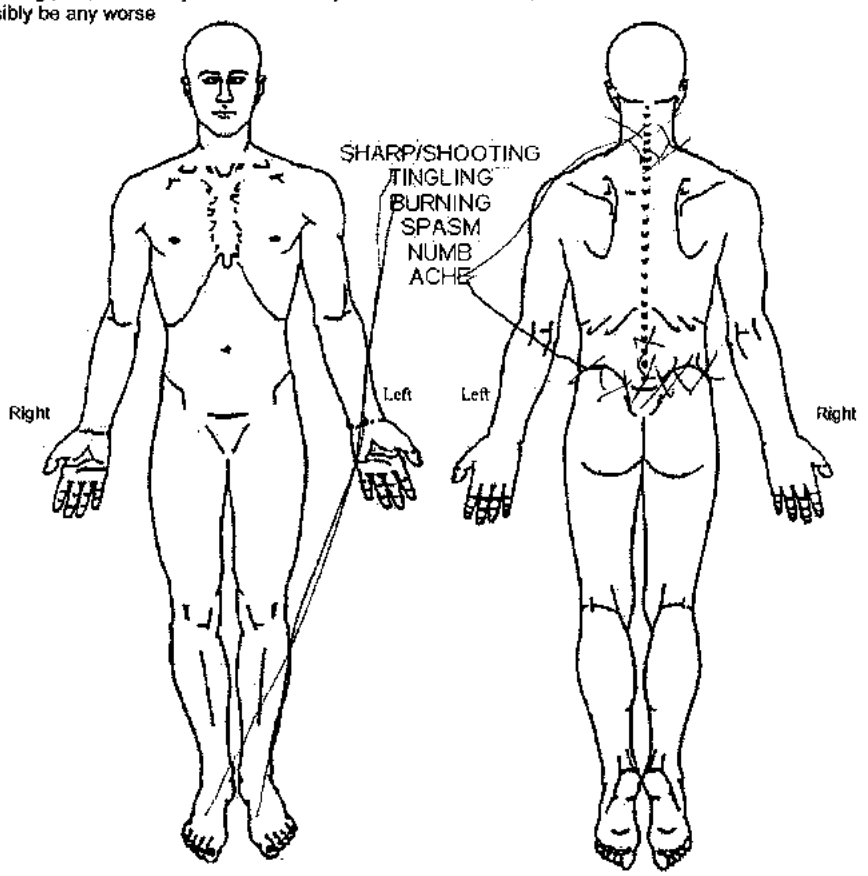
How far can you walk? _____

How long can you sit? _____

How long can you stand? _____

Are you working? _____

Are you able to work? _____



Name: Joyce Sokoa

Date: 6-1-17

JS456

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www.paininstitute.com

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Please answer the following questions:

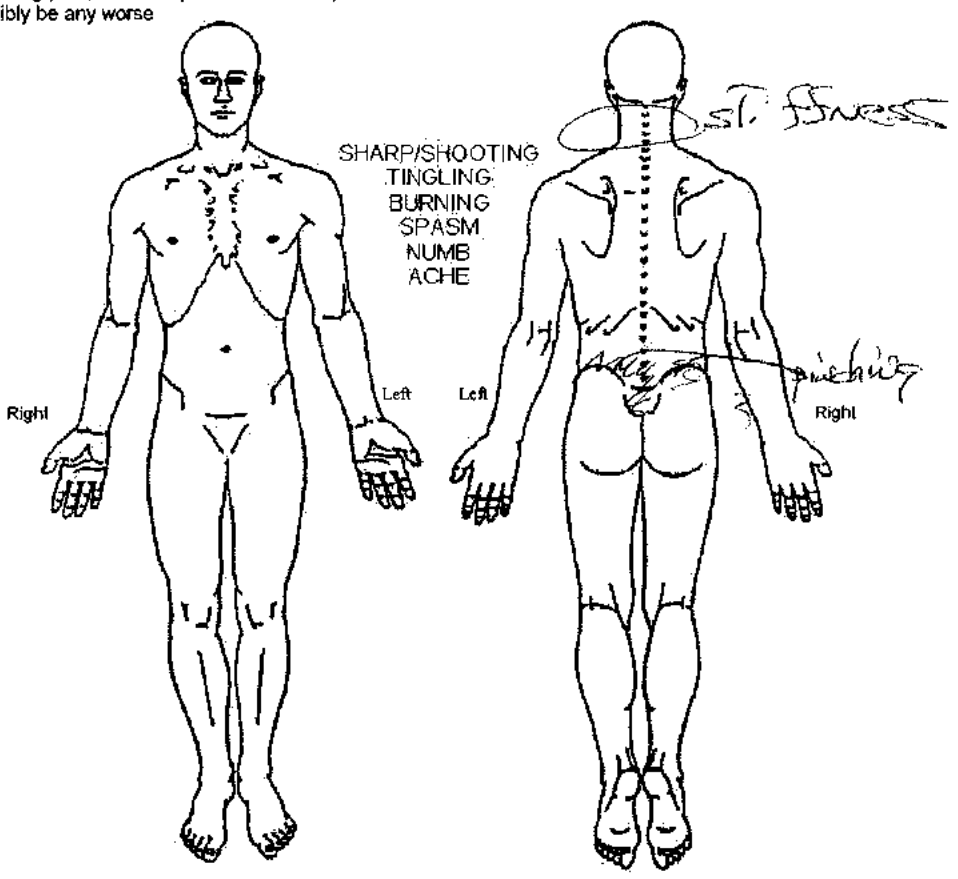
How far can you walk? _____

How long can you sit? _____

How long can you stand? _____

Are you working? _____

Are you able to work? _____



Name: Jaye Jobare

Date: 5/11/17

JS457

INFORMED CONSENT *Pain Institute of Nevada*

Spinal Injections

Procedure(s) to be performed

- ☑ Cervical Epidural Injections
- ☑ Thoracic Epidural Injections
- ☑ Lumbar Epidural Injections
- ☑ Epidural Blood Patch
- ☑ Cervical Facet Joint / Medial Branch Block
- ☑ Thoracic Facet Joint / Medial Branch Block
- ☑ Lumbar Facet Joint / Medial Branch Block
- ☑ Hardware Injections
- ☑ Sacroiliac Joint

Physician

- ☑ Walter Kidwell M.D.
- ☑ Katherine Travnicek M.D

DESCRIPTION AND PURPOSE OF PROCEDURE

Medications are injected into and around the structures of the spine to improve pain and / or aid in diagnosing a structure as being a "pain generator". The medications to be injected may include Local Anesthetics, Corticosteroids, or normal saline. Corticosteroids reduce pain by decreasing inflammation.
Fluoroscopy will generally be used to guide needle placement. Sedation will be used for comfort unless specifically not requested. There are no guarantees injections will help your pain and, in rare cases, pain may actually be made worse. The degree and duration of pain relief varies from person to person, and additional injections may be needed. A catheter is inserted into the epidural space to facilitate the procedure during caudal epidural injections. Steroids are usually injected as part of the procedure. Epidural Blood Patch: Blood drawn from your arm is injected into the epidural space to treat a spinal headache from a dural puncture (spinal tap).

BENEFITS

Therapeutic injections may improve pain and possibly avoid the need for surgery or other treatments
Diagnostic injections aid in determining pain generators to guide future care.

ALTERNATIVES

Alternatives may include conservative care, medications, and / or surgery.

RISKS OF THE PROCEDURE

Complications are rare and include: Bleeding, infection, damage to nerves and structures of the spine, spinal headache, perforation of organs, collapsed lung, reaction to medications, increased pain, seizure, stroke, paralysis, damage to fetus if pregnant and death. You may be given antibiotics during the procedure. Your usual pain may be increased for a few days after the procedure. The risk of injection of corticosteroids include thinning of bones, pathologic fractures, weakening of ligaments, damage to tissues, avascular necrosis of the hip, cataracts, decreased immunity, reaction to medication. Complications are rare. Side effects that occur commonly include flushing, fluid retention, rash, weight gain, insomnia, and headache. Surgery may be required to treat some complications. Diabetics will have significant increased in blood sugars and will need to monitor their blood sugar levels closely and adjust medication as directed by their family physician. Sedation is used for patient comfort and to facilitate performance of the procedure. Complications of sedation are very rare and include aspiration, pneumonia, and loss of airway requiring emergency resuscitation or surgery. The risk of complications requiring transfusion is extremely low. The risks of transfusion of blood products include transfusion reaction, infection such as HIV or Hepatitis, and death.

EPIDURAL OFF LABEL MEDICATIONS

One of the medications to be injected includes CORTICOSTEROIDs. Although all are safe in humans and have been used since 1950s successfully in the epidural space, corticosteroids are NOT FDA approved for use in the epidural space and considered "OFF LABEL." The FDA has not limited or banned use of corticosteroids for epidurals.

I verify that I have read the above and that the nature and purpose of the procedure(s) have been explained to me (as noted above) as well as the risks of potential complications, side effects, benefits and alternatives. I have had the opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that no guarantees have been made to me regarding outcome. I give my consent to and request the performance of the above named procedure(s).

I request the administration of anesthesia as may be considered necessary for my comfort or safety except as noted below.

I understand that photographs or videotaping may be requested for educational or legal purposes. I give my consent to taking such pictures or videos except as noted below.

Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center

Exceptions to procedure, surgery, anesthesia or photography _____ (if none so state)

Joyce Sekera — 3/15/17 — *(signature of patient or guardian)* *(date)* *(signature of witness)*

PHYSICIAN: I have counseled the patient regarding the nature and purpose of the proposed procedure including the attendant risks, benefits and alternatives to the procedure.

Sekera, Joyce — *(signature of counseling physician)*

PATIENT IDENTIFICATION **JS458**

(702) 467-5457 VVSC 4/3/17

Head

Neck

LUE

RUE

MB

LB

LLE

RLE

Sacrum
Abd
Groin
Testicles

HNP

DP

DB

FJA

FSN

CS

FS

Bleed

NSAID

SBE

Heart

Lung

OSA

DM

Allergies

SNRB

TFES

TLES
w cath

CAUDAL

FJI EUF

MBB Bilateral L5S1

HW ØNP

SIJ

PT ID	DATE

JS459

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www.paininstitute.com

Pain Diagram

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9 /10: Severe Pain, Severely limited ability to perform daily activities
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

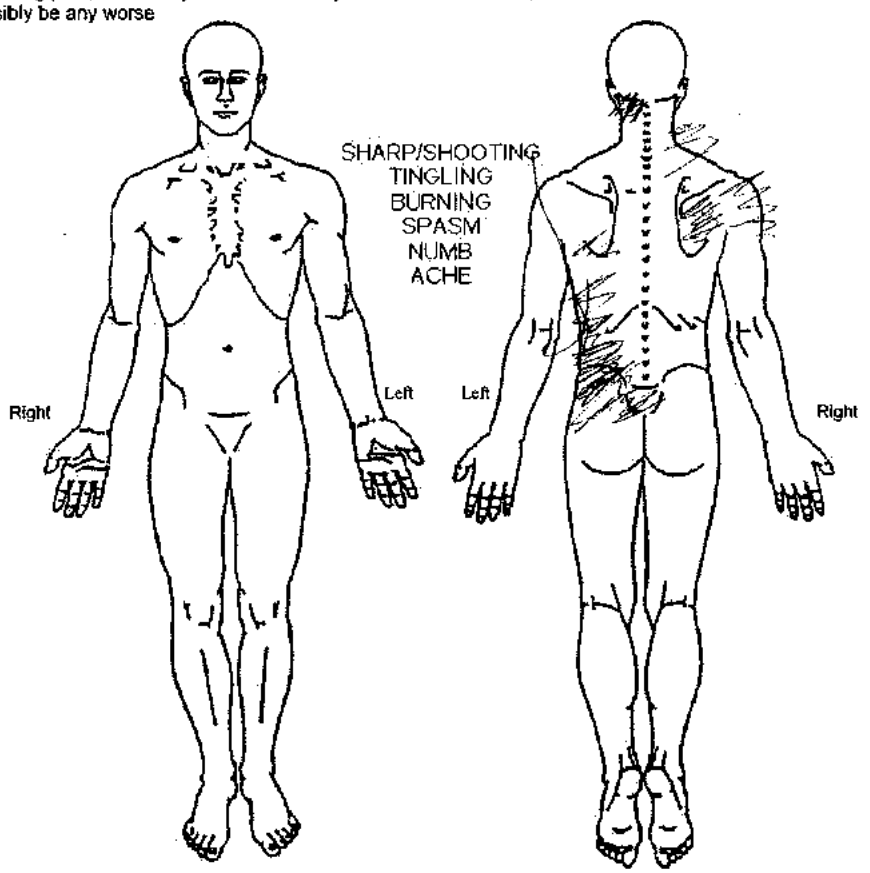
How far can you walk? less than 5 min

How long can you sit? ↓

How long can you stand? _____

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Date: 3-15-17

JS460

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

7435 W. Azure Drive, Suite 190
Las Vegas, NV 89130
Ph: (702) 878-8252
Fax: (702) 878-9096

INSTRUCTIONS FOR INJECTION PROCEDURE

BEFORE YOUR INJECTION
Must follow the instructions below to **avoid cancellation of your procedure.**

- Please arrive on time with insurance card and picture ID. Plan on being there for approximately 2-3 hours.
- Physician fees and co-pays are due to our office 48 hours prior to the procedure. Surgery center fees and co-pays are due at time of procedure at the surgery center.
- You will need a driver (family member or friend) after the procedure. NO UBER, LYFT, OR TAXIS.
- 7 days prior to the procedure, **STOP** the following medications:
  Arthrotec, Aspirin, Ascriptin, Bufferin, diclofenac (Voltaren), Excedrin, etodolac (Lodine), Fiorinal, flurbiprofen (Ansaid), ibuprofen (Advil, Motrin), indomethacin (Indocin), ketoprofen, ketorolac (Toradol), mobic (Meloxicam), nabumetone (Relafen), naproxen (Aleve), Norgesic, piroxicam (Feldene), sulindac (Clinoril).
  Vitamin E and all over the counter herbal medications.
  Plavix, coumadin (Warfarin): Must have medical clearance from prescribing physician to discontinue these medications. Patients on coumadin will need PT/INR bloodwork completed the night before the procedure.
- Diabetic patients must get their last HbA1C to our office if having spinal cord stimulation surgery. Check blood sugar the morning of the procedure. **If your blood sugar is more than 150,** call our office to reschedule your procedure.
- Diabetic patients must check blood sugar the morning of the procedure. If your **blood sugar is more than 150,** call our office to reschedule your procedure.
- If you are sick or have an acute infection or **are on antibiotics,** please call the office to reschedule your procedure.
- **Do not** eat or drink 8 hours prior to your arrival time.
- You can take your regular medications (except for the medications listed above) with a sip of water.
- Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center.

Please note we **do not write prescriptions at the surgery center**. You will need to schedule an appointment with our office. If you have any questions or concerns, don't hesitate to ask. Signature indicates you have read the instructions and will comply to avoid cancellation of your procedure.

Patient Signature

Rivera, Joyce
Patient Print Name

Witness Signature

3/16/17
Date

AFTER YOUR INJECTION

- Do not drive for 24 hours.
- Have someone assist you with walking for the first 2-3 hours after the injection, then resume your normal activities.
- Do not shower or bathe until the day after the procedure.
- You may resume discontinued medication the day after the procedure.
- After local anesthetic wears off, you may experience pain at injection site. Apply ice for 1-2 days, then apply heat.
- Common side effects due to corticosteroid injection: fluid retention, facial flushing, and insomnia for 1-2 days.
- Rare complications: numbness or weakness that is progressively getting worse, loss of bowel or bladder control, fever more than 100.5, nausea and vomiting. Please call our office or answering service. If you feel it's a life threatening emergency, go to the emergency department or call 911 for ambulance transport.

See Reverse Side for Surgery Center Location Maps and Phone Numbers

JS461

INFORMED CONSENT *Pain Institute of Nevada*

Spinal Injections

Procedure(s) to be performed

- ☒ Cervical Epidural Injections
- ☒ Thoracic Epidural Injections
- ☒ Lumbar Epidural Injections
- ☒ Epidural Blood Patch
- ☒ Cervical Facet Joint / Medial Branch Block
- ☒ Thoracic Facet Joint / Medial Branch Block
- ☒ Lumbar Facet Joint / Medial Branch Block
- ☒ Hardware Injections
- ☒ Sacroiliac Joint

Physician

- ☒ Walter Kidwell M.D.
- ☒ Katherine Travnicek M.D

DESCRIPTION AND PURPOSE OF PROCEDURE

Medications are injected into and around the structures of the spine to improve pain and / or aid in diagnosing a structure as being a "pain generator". The medications to be injected may include Local Anesthetics, Corticosteroids, or normal saline. Corticosteroids reduce pain by decreasing inflammation.
Fluoroscopy will generally be used to guide needle placement. Sedation will be used for comfort unless specifically not requested. There are no guarantees injections will help your pain and, in rare cases, pain may actually be made worse. The degree and duration of pain relief varies from person to person, and additional injections may be needed. A catheter is inserted into the epidural space to facilitate the procedure during caudal epidural injections. Steroids are usually injected as part of the procedure. Epidural Blood Patch: Blood drawn from your arm is injected into the epidural space to treat a spinal headache from a dural puncture (spinal tap).

BENEFITS

Therapeutic injections may improve pain and possibly avoid the need for surgery or other treatments.
Diagnostic injections aid in determining pain generators to guide future care.

ALTERNATIVES

Alternatives may include conservative care, medications, and / or surgery.

RISKS OF THE PROCEDURE

Complications are rare and include: Bleeding, infection, damage to nerves and structures of the spine, spinal headache, perforation of organs, collapsed lung, reaction to medications, increased pain, seizure, stroke, paralysis, damage to fetus if pregnant and death. You may be given antibiotics during the procedure. Your usual pain may be increased for a few days after the procedure. The risk of injection of corticosteroids include thinning of bones, pathologic fractures, weakening of ligaments, damage to tissues, avascular necrosis of the hip, cataracts, decreased immunity, reaction to medication. Complications are rare. Side effects that occur commonly include flushing, fluid retention, rash, weight gain, insomnia, and headache. Surgery may be required to treat some complications. Diabetics will have significant increased in blood sugars and will need to monitor their blood sugar levels closely and adjust medication as directed by their family physician. Sedation is used for patient comfort and to facilitate performance of the procedure. Complications of sedation are very rare and include aspiration, pneumonia, and loss of airway requiring emergency resuscitation or surgery. The risk of complications requiring transfusion is extremely low. The risks of transfusion of blood products include transfusion reaction, infection such as HIV or Hepatitis, and death.

EPIDURAL OFF LABEL MEDICATIONS

One of the medications to be injected includes CORTICOSTEROIDs. Although all are safe in humans and have been used since 1950s successfully in the epidural space, corticosteroids are NOT FDA approved for use in the epidural space and considered "OFF LABEL." The FDA has not limited or banned use of corticosteroids for epidurals.

I verify that I have read the above and that the nature and purpose of the procedure(s) have been explained to me (as noted above) as well as the risks of potential complications, side effects, benefits and alternatives. I have had the opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that no guarantees have been made to me regarding outcome. I give my consent to and request the performance of the above named procedure(s).

I request the administration of anesthesia as may be considered necessary for my comfort or safety except as noted below.

I understand that photographs or videotaping may be requested for educational or legal purposes. I give my consent to taking such pictures or videos except as noted below.

Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center

Exceptions to procedure, surgery, anesthesia or photography _____ (If none so state)

Sekera, Joyce — 2/20/17 — S Rivera

(signature of patient or guardian) *(date)* *(signature of witness)*

PHYSICIAN: I have counseled the patient regarding the nature and purpose of the proposed procedure including the attendant risks, benefits and alternatives to the procedure.

Sekera, Joyce 3/22/56 *(signature of counseling physician)*

PATIENT IDENTIFICATION

VVSC 3/9/17
(702) 467-5457

JS462

Head

Neck

MB

LB

Sacrum
Abd
Groin
Testicles

LUE

RUE

LLE

RLE

HNP

DP

DB

FJA

FSN

CS

FS

Bleed

NSAID

SBE

Heart

Lung

OSA

DM

Allergies

SNRB

TFES

TLES
w cath

CAUDAL

FJI E~~M~~F → Bilateral L5-S1 FJI

NP

MBB

HW

SIJ

PT ID	DATE

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS463

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
Fax: (702) 878-9096
www.paininstitute.com

Pain Diagram

In regards to your pain in the last week:

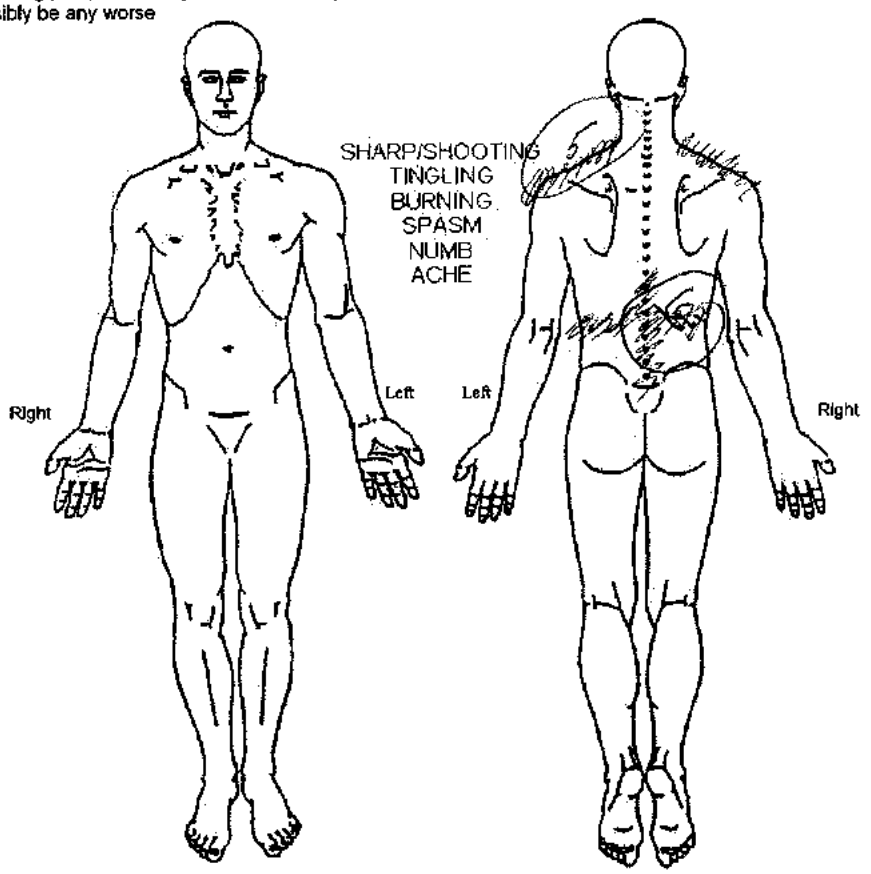
- Please shade in the areas that best represent your pain.
- Draw a line from the pain description to the area of your pain.
- Indicate your current pain score 0/10 - 10/10 for each area of your pain.

Pain Scale

0 /10: No Pain
1 /10: Minimal pain
2 /10: Mild pain, No impact on daily activities
3 /10: Mild pain, Minimal impact of daily activities
4 /10: Moderate pain, Minimal limitations of daily activities
5 /10: Moderate pain, Some limitations of daily activities
6 /10: Moderate pain, Moderate limitations of daily activities
7 /10: Moderate/Severe pain, Very limited daily activities
8 /10: Moderate/Severe pain, Very difficult to perform daily activities
9 /10: Severe Pain, Severely limited ability to perform daily activities
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

How far can you walk? 15 min
How long can you sit? 15 min
How long can you stand? 15 min
Are you working? NO
Are you able to work? NO



Name: Joyce Sekera

Date: 2/20/17

JS464

INFORMED CONSENT

Pain Institute of Nevada

Peripheral Nerve Blocks, Trigger Point, Tendon, Ligament and Joint Injection

Procedure(s) to be performed

- ☒ Occipital Nerve Blocks
- ☒ Ilioinguinal Nerve Blocks
- ☒ Genitofemoral Nerve Blocks
- ☒ Lateral Femoral Cutaneous Nerve Blocks
- ☒ Genicular Nerve Blocks_____
- ☒ Other Nerve Blocks _____
- ☒ Trigger Point Injections
- ☒ Ligament and Tendon Injections
- ☒ Sacroiliac Joint Injections
- ☒ Hip Joint Injections
- ☒ Other Joint Injections_____
- ☒ Bursa Injections_____

Physician

- ☒ Walter Kidwell M.D.
- ☒ Katherine Travnicek M.D.

DESCRIPTION AND PURPOSE OF PROCEDURE: Medications are injected onto nerves, ligaments and tendons, into joints and trigger points of muscles to improve pain and / or aid in diagnosing a structure as being a "pain generator". The medications to be injected may include Local Anesthetics, Corticosteroids (Cortisone like medications) or pain medications. Corticosteroids reduce pain by decreasing inflammation. Fluoroscopy may be used to guide needle placement. Sedation may be used for comfort unless specifically not requested. There are no guarantees injections will help your pain and, in rare cases, pain may actually be made worse. The degree and duration of pain relief varies from person to person, and additional injections may be needed.

BENEFITS: Therapeutic injections may improve pain and possibly avoid the need for surgery or other treatments. Diagnostic injections aid in determining pain generators to guide future care.

ALTERNATIVES: Alternatives may include conservative care, medications and / or surgery.

RISKS OF THE PROCEDURE: Complications are rare and include: bleeding, infection, damage to nerves and structures of the area injected, headache, perforation of organs, collapsed lung, reaction to medications, increased pain, seizure, stroke, paralysis, damage to fetus if pregnant and death. You may be given antibiotics during the procedure. Your usual pain may be increased for a few days after the procedure. The risk of injection of corticosteroids include thinning of bones, pathologic fractures, weakening of ligaments, damage to tissues, avascular necrosis of the hip, cataracts, decreased immunity, and reaction to medication. Complications are rare. Side effects that occur commonly include flushing, fluid retention, rash, weight gain, insomnia, and headache. Surgery may be required to treat some complications. Diabetics will have significant increased in blood sugars and will need to monitor their blood sugar levels closely and adjust medication as directed by their family physician. Sedation is used for patient comfort and to facilitate performance of the procedure. Complications of sedation are very rare and include aspiration, pneumonia, and loss of airway requiring emergency resuscitation or surgery. The risk of complications requiring transfusion is extremely low. The risks of transfusion of blood products include transfusion reaction, infection such as HIV or Hepatitis, and death.

I verify that I have read the above and that the nature and purpose of the procedure(s) have been explained to me (as noted above) as well as the risks of potential complications, side effects, benefits and alternatives. I have had the opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that no guarantees have been made to me regarding outcome. I give my consent to and request the performance of the above named procedure(s).

I request the administration of anesthesia as may be considered necessary for my comfort or safety except as noted below.

I understand that photographs or videotaping may be requested for educational or legal purposes. I give my consent to taking such pictures or videos except as noted below.

Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center.

Exceptions to procedure, surgery, anesthesia or photography _____ (if none so state)

Joyce Sekera — *(signature of patient or guardian)*

2/20/17 — *(date)*

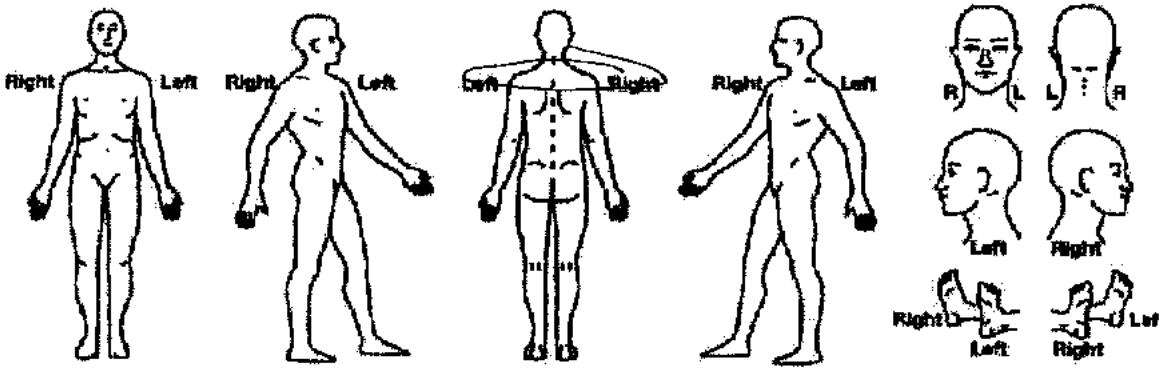
(signature of witness)

PHYSICIAN: I have counseled the patient regarding the nature and purpose of the proposed procedure(s) including the attendant risks, benefits and alternatives to the procedure.

Sekera, Joyce
Patient Identification

(signature of counselling physician)

JS465



Bleed

NSAID

SBE

Heart

Lung

OSA

DM

PT ID	DATE

JS466

WALTER M. KIDWELL, M.D.
PAIN INSTITUTE OF NEVADA

7435 W. Azure Drive, Suite 190
Las Vegas, NV 89130
Ph: (702) 878-8252
Fax: (702) 878-9096

INSTRUCTIONS FOR INJECTION PROCEDURE

BEFORE YOUR INJECTION

Must follow the instructions below **to avoid cancellation of your procedure.**

- Please arrive on time with insurance card and picture ID. Plan on being there for approximately 2-3 hours.
- Physician fees and co-pays are due to our office 48 hours prior to the procedure. Surgery center fees and co-pays are due at time of procedure at the surgery center.
- You will need a driver (family member or friend) after the procedure. NO UBER, LYFT, OR TAXIS.
- 7 days prior to the procedure, **STOP** the following medications:
  Arthrotec, Aspirin, Ascriptin, Bufferin, diclofenac (Voltaren), Excedrin, etodolac (Lodine), Florinal, flurbiprofen (Ansaid), ibuprofen (Advil, Motrin), indomethacin (Indocin), ketoprofen, ketorolac (Toradol), mobic (Meloxicam), nabumetone (Relafen), naproxen (Aleve), Norgesic, piroxicam (Feldene), sulindac (Clinoril).
  Vitamin E and all over the counter herbal medications.
  Plavix, coumadin (Warfarin): Must have medical clearance from prescribing physician to discontinue these medications. Patients on coumadin will need PT/INR bloodwork completed the night before the procedure.
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- Diabetic patients must check blood sugar the morning of the procedure. If your **blood sugar is more than 150**, call our office to reschedule your procedure.
- If you are sick or have an acute infection or are **on antibiotics**, please call the office to reschedule your procedure.
- **Do not** eat or drink 8 hours prior to your arrival time.
- You can take your regular medications (except for the medications listed above) with a sip of water.
- Disclosure: Dr. Kidwell has part ownership at Valley View Surgery Center.

Please note we **do not write prescriptions at the surgery center**. You will need to schedule an appointment with our office. If you have any questions or concerns, don't hesitate to ask. Signature indicates you have read the instructions and will comply to avoid cancellation of your procedure.

Patient Signature

Joyce Sekera
Patient Print Name

Witness Signature

2/20/17
Date

AFTER YOUR INJECTION

- Do not drive for 24 hours.
- Have someone assist you with walking for the first 2-3 hours after the injection, then resume your normal activities.
- Do not shower or bathe until the day after the procedure.
- You may resume discontinued medication the day after the procedure.
- After local anesthetic wears off, you may experience pain at injection site. Apply ice for 1-2 days, then apply heat.
- Common side effects due to corticosteroid injection: fluid retention, facial flushing, and insomnia for 1-2 days.
- Rare complications: numbness or weakness that is progressively getting worse, loss of bowel or bladder control, fever more than 100.5, nausea and vomiting. Please call our office or answering service. If you feel it's a life threatening emergency, go to the emergency department or call 911 for ambulance transport.

See Reverse Side for Surgery Center Location Maps and Phone Numbers

JS467

Pain Institute of Nevada
7435 W. Azure Dr. Ste 190
Las Vegas, NV 89130

Ph: (702) 878-8252
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Pain Diagram

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Pain Scale

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4 /10: Moderate pain, Minimal limitations of daily activities
5 /10: Moderate pain, Some limitations of daily activities
6 /10: Moderate pain, Moderate limitations of daily activities
7 /10: Moderate/Severe pain, Very limited daily activities
8 /10: Moderate/Severe pain, Very difficult to perform daily activities
9 /10: Severe Pain, Severely limited ability to perform daily activities
10/10: Severe Disabling pain, essentially unable to do any activities whatsoever, cannot possibly be any worse

Please answer the following questions:

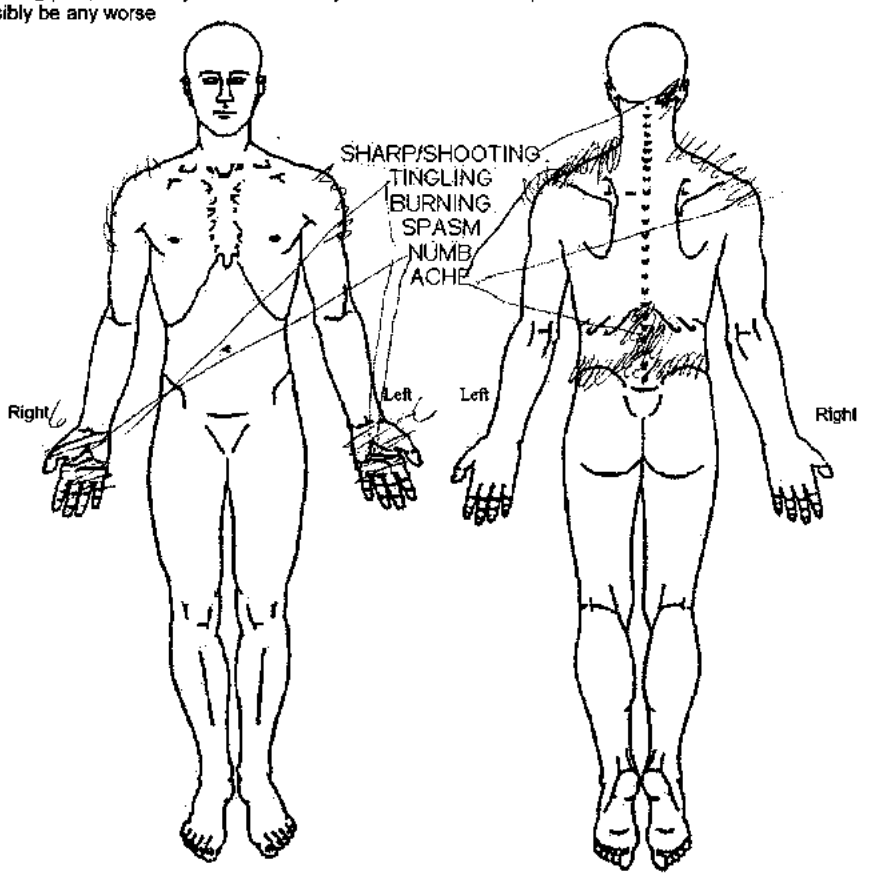
How far can you walk? Times easily

How long can you sit? _____

How long can you stand? _____

Are you working? NO

Are you able to work? NO



Name: Joyce Sekera

Joyce Sekera

Date: 1-30-17

JS468

Nevada PRESCRIPTION MONITORING PROGRAM

Nevada Prescription Monitoring Program
For assistance using this application, please contact:
1-855-5NV-4PMP OR pmp@pharmacy.nv.gov,

Report Prepared: 06/19/2017

Patient Report

Date Range: 06/19/2016 – 06/19/2017

Joyce P Sekera

Linked Records

Name	DOB	ID	Gender	Address
JOYCE SEKERA	03/22/1956	1	female	7840 NESTING PINE PL LAS VEGAS NV 89143

Report Criteria

First Name: Joyce P, **Last Name:** Sekera, **DOB:** 03/22/1956, **ZIP Code:** 89143, **City:** Las Vegas, **State:** NV, **Phone:** 7024675457, **SSN:** , **DL:**

Summary

Prescriptions:1	Prescribers:1	Pharmacies:1	Private Pay:0	Active Daily MME:0.0

Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy*	Refills	MME/D	Pymt Type	PMP
11/09/2016	1	11/04/2016	HYDROCODON-ACETAMINOPHEN 5-325	15.0	5	RA TAY	1460267	WALGR (0055)	0	15.0	Worker's Comp	NV

*Pharmacy is created using a combination of pharmacy name and the last four digits of the pharmacy license number.

Prescribers

Name	Address	City	State	Zip	Phone
TAYLOR, RACHAEL A	7842 W SAHARA AVE	LAS VEGAS	NV	89117	7023056339

Dispensers

Pharmacy	Address	City	State	Zip	Phone
WALGREEN CO. (0055)	7755 N DURANGO DR	LAS VEGAS	NV	89131	7023864728

Disclaimer:

Report contents are based on data entered by dispensers and their staff, and may contain errors. The Board of Pharmacy recommends independent verification with dispensers when prudent or necessary. Willful disclosure of prescription information may be subject to disciplinary action, civil penalties or criminal action.

Nevada PRESCRIPTION MONITORING PROGRAM

Nevada Prescription Monitoring Program
For assistance using this application, please contact:
1-855-5NV-4PMP OR pmp@pharmacy.nv.gov, NV

Report Prepared: 01/04/2017

Patient Report

Date Range: 01/04/2014 – 01/04/2017

Joyce P Sekera

Linked Records

Name	DOB	ID	Gender	Address
JOYCE SEKERA	03/22/1956	1	female	7840 NESTING PINE PL LAS VEGAS NV 89143

Report Criteria

First Name: Joyce P, **Last Name:** Sekera, **DOB:** 03/22/1956, **ZIP Code:** 89143, **City:** Las Vegas, **State:** NV, **Phone:** 702-467-5457, **SSN:** , **DL:**

Summary

Prescriptions:1	Prescribers:1	Pharmacies:1	Private Pay:0	Active Daily MME:0.0

Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy*	Refills	MME/D	Pymt Type	PMP
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Name	Address	City	State	Zip	Phone
TAYLOR, RACHAEL A	7842 W SAHARA AVE	LAS VEGAS	NV	89117	7023056339

Dispensers

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Disclaimer:

Report contents are based on data entered by dispensers and their staff, and may contain errors. The Board of Pharmacy recommends independent verification with dispensers when prudent or necessary. Willful disclosure of prescription information may be subject to disciplinary action, civil penalties or criminal action.

2828 LIEN

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

00000-0000

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) [X] FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 31614

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SEKERA JOYCE P

3. PATIENT'S BIRTH DATE MM DD YY: 03 22 1956 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SEKERA JOYCE P

5. PATIENT'S ADDRESS (No., Street): 7840 NESTING PINE PL

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 7840 NESTING PINE PL

CITY: LAS VEGAS STATE: NV

8. RESERVED FOR NUCC USE

CITY: LAS VEGAS STATE: NV

ZIP CODE: 89143 TELEPHONE (Include Area Code): (702) 4675457

ZIP CODE: 89143 TELEPHONE (Include Area Code): (702) 4675457

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 03 22 1956 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) NV

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Authorization on File

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN KATHERINE D TRAVNICEK MD

17a.

17b. NPI 1356467831

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M54.5 B. M47.817 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 5382EXL-1

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 07 17	12 07 17	11		99214		AB	450 00	1		NPI	1356467831
2											NPI	
3											NPI	
4											NPI	
5												
6												

JS473

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 880245302 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 31614 00

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 450 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12 11 2017

32. SERVICE FACILITY LOCATION INFORMATION

PAIN INSTITUTE OF NEVADA
7435 W AZURE DRIVE SUITE 190
LAS VEGAS NV 89130-4427

a. 1376571331 b.

33. BILLING PROVIDER INFO & PH # (702) 8788252

KATHERINE D TRAVNICEK MD
7065 W ANN ROAD #130-548
LAS VEGAS NV 89130-4990

a. 1376571331 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

Run Date: 1/16/18

Patient Procedures Ledger

WALTER M KIDWELL MD, 7065 W ANN ROAD #130-548, LAS VEGAS, NV 89130-4990

(702)878-8252

Acct Num: 31614.00

JOYCE P SEKERA
7840 NESTING PINE PL

LAS VEGAS, NV 89143

SSN: ***-**-430 **DOB:** 3/22/1956 **Sex:** F
Pat Type: 70/ARF
Empl/Sch:
Home Ph: 702 467-5457 **Work Ph:** 000 000-0000
Cell Ph: 702 467-5457
Email:

Ins:4941 GALLIHER ESQ, KEIT **Pol #:** 31614-7180 **Group:**

Date	Patient	Procedure Description	Amount	DailyTot	Balance
11/30/17	JOYCE	6463550/FACET NERVE DESTRUCTION	4200.00	4200.00	15550.0C
11/30/17	JOYCE	99152/CONSCIOUS SEDATION 15 MINS		4200.00	15550.0C
1/11/18	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	16000.0C

JS474

Run Date: 1/16/18

Patient Procedures Ledger

WALTER M KIDWELL MD, 7065 W ANN ROAD #130-548, LAS VEGAS, NV 89130-4990
(702)878-8252

Acct Num: 31614.00

JOYCE P SEKERA
7840 NESTING PINE PL

LAS VEGAS, NV 89143

SSN: ***-**-430 DOB: 3/22/1956 Sex: F
Pat Type:
Empl/Sch:
Home Ph: 702 467-5457 Work Ph: 000 000-0000
Cell Ph: 702 467-5457
Email:

Ins:4941 GALLIHER ESQ, KEIT Pol #: 31614-7180 Group:

Date	Patient	Procedure Description	Amount	DailyTot	Balance
3/15/17	JOYCE	NCNS/NCNS	100.00	100.00	100.0C
					100.0C
					100.0C
					100.0C
12/07/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	550.0C
					550.0C
1/09/17	JOYCE	99244/CONSULT OFFICE 4	900.00	900.00	1450.0C
1/30/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	1900.0C
2/20/17	JOYCE	9921425/EST. PT OFFICE 4	450.00	450.00	2350.0C
2/20/17	JOYCE	20553/TRIGGER PT. 3 OR MORE MUSC	300.00	750.00	2650.0C
3/09/17	JOYCE	6449350/FACET JOINT/NERVE LUM/SA	3000.00	3000.00	5650.0C
3/09/17	JOYCE	99152/CONSCIOUS SEDATION 15 MINS		3000.00	5650.0C
3/15/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	6100.0C
5/08/17	JOYCE	6449350/FACET JOINT/NERVE LUM/SA	3000.00	3000.00	9100.0C
5/08/17	JOYCE	99152/CONSCIOUS SEDATION 15 MINS		3000.00	9100.0C
5/11/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	9550.0C
6/01/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	10000.0C
6/26/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	10450.0C
7/10/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	10900.0C
10/23/17	JOYCE	99214/EST. PT OFFICE 4	450.00	450.00	11350.0C

JS475

VALLEY VIEW SURGERY CENTER

IM box# _____

Patient Name: Joyce Sehera

Release of Information Checklist Patient's MR# 153654

1. **Authorization is Received Date:** 12/4/17 **From:** The Gallicher Law Firm

2. **VERIFY authorization is valid:** ____ **NOT APPLICABLE - Subpoena,**
   - X **Authorization is valid** **DOS requested:** 5/9/17 to present
   - OR ____ **auth = lien as signed at admission** **Actual DOS:** 11/30/17
   - X **Enter in ROI Log (excel)**

   If NO ____ Notify requesting party that authorization is not valid and return with the request. (M:Medical Records/Release of Information/Return ROI.doc)

3. X **Make comment in AdvantX of request for record, pending copy by MedR / IM retrieval**

4. **Chart audit**
   - ____ Chart to CNO reviewed by: ____
   - X record has been previously requested/audited
   - ____ chart scanned to O-drive on ____

5. **BILLING DEPARMENT: statement requested?**
   - ____ NO
   - ____ Yes – Billing Records Attached ____
   - ____ Yes/Lien holder Acct – cc: fax to Billing Department to request bill (date/initials) ____
   - ____ ***Refer to:*** ☐ EAC ☐ Recovery Partners ☐ Canyon Medical
     ☐ EZ Business ☐ Other: ____

   Billing Staff Portion Completed By/Date: ____

6. ____ **Record is copied by MedR** **XRays/Films requested Y / N**
   If yes, 'No Films' declaration included / attached ____
   ____ Date Copied by ____ /MedR Name

   Copied: ☐ All dates of service Billing attached ☐ Yes ☐ No
   ☐ specify DOS ____
   ☐ Min required (face sheet, H&P, op report, path report)

7. ____ **Make note in AdvantX**
   - ____ Comment 'Copied by MedR mm/dd/yy'
   - ____ Information Disclosure screen in Registration
   - ____ File request in back, on left side of chart

CERTIFICATE OF CUSTODIAN OF RECORDS

STATE OF NEVADA)
) SS:
COUNTY OF CLARK)

COMES NOW, Isai Saavedra, being duly sworn deposes and says as follows:

1. That the deponent is the Authorized Agent for Valley View Surgery Center, and in such capacity is the custodian of records of the office or institution.

2. That on the 7 day of December, 20 17, the deponent received a HIPAA compliant records authorization/subpoena for the release of records for :

Patient Name : Joyce Sekera

Date of Birth : 03/22/1956

3. That the deponent has examined the originals of any and all records and has made a true and exact copy of the records and provide a true and complete copy of those documents are attached hereto.

4. That the original of the records was made at or near the time of the act and/or event recited therein by or from information transmitted by a person with knowledge in the course of a regularly conducted activity of the deponent, or the office or institution in which the deponent is engaged.

☑ Medical Records ☑ Billing Records ☐ Radiology ☐ Other

OR

5. _____That the Deponent has found no records/materials.
   a. _____ This person cannot be located after a thorough search of our files
   b. _____ have been destroyed/purged. Records/Materials are maintained for ____ years.
   c. _____ were lost, misplaced, stolen, or damaged beyond repair
   d. _____ no records for dates specified of : _____
   e. _____ other : _____
   f. _____ no radiology or _____located at another facility : _____
   g. _____ Billing is with : _____

CUSTODIAN SIGNATURE

SUBSCRIBED AND SWORN to before me this 7 day of December, 20 17

NOTARY PUBLIC in and for the said COUNTY and STATE

My Commission expires Aug 23, 2020

C. LOPEZ
Notary Public - State of Nevada
County of Clark
APPT. NO. 16-5574-1
My App. Expires Aug. 23, 2020

JS477

CERTIFICATE OF CUSTODIAN OF RECORDS

STATE OF NEVADA)
) SS:
COUNTY OF CLARK)

COMES NOW, Isai Saavedra, being duly sworn deposes and says as follows:

1. That the deponent is the Authorized Agent for Valley View Surgery Center, and in such capacity is the custodian of records of the office or institution.

2. That on the 7 day of December, 20 17, the deponent received a HIPAA compliant records authorization/subpoena for the release of records for :

Patient Name : Joyce Sekera

Date of Birth : 03/22/1956

3. That the deponent has examined the originals of any and all records and has made a true and exact copy of the records and provide a true and complete copy of those documents are attached hereto.

4. That the original of the records was made at or near the time of the act and/or event recited therein by or from information transmitted by a person with knowledge in the course of a regularly conducted activity of the deponent, or the office or institution in which the deponent is engaged.

☑ Medical Records ☑ Billing Records ☐ Radiology ☐ Other

OR

5. _____That the Deponent has found no records/materials.
   a. _____ This person cannot be located after a thorough search of our files
   b. _____ have been destroyed/purged. Records/Materials are maintained for ____ years.
   c. _____ were lost, misplaced, stolen, or damaged beyond repair
   d. _____ no records for dates specified of : _____
   e. _____ other : _____
   f. _____ no radiology or _____located at another facility : _____
   g. _____ Billing is with : _____

CUSTODIAN SIGNATURE

SUBSCRIBED AND SWORN to before me this 7 day of December, 20 17

NOTARY PUBLIC in and for the said COUNTY and STATE

My Commission expires Aug 23, 2020

C. LOPEZ
Notary Public - State of Nevada
County of Clark
APPT. NO. 16-5574-1
My App. Expires Aug. 23, 2020

JS478

ICATE OF CUSTODIAN OF RE

STATE OF NEVADA)
) SS:
COUNTY OF CLARK)

COMES NOW, Refugio Medina, being duly sworn deposes and says as follows:

1. That the deponent is the Authorized Agent for VALLEY VEIW, and in such capacity is the custodian of records of the office or institution.

2. That on the 28 day of MARCH, 20 17, the deponent received a HIPAA compliant records authorization/subpoena for the release of records for :

Patient Name : JOYCE SEKERA

Date of Birth : 03/22/1956

3. That the deponent has examined the originals of any and all records and has made a true and exact copy of the records and provide a true and complete copy of those documents are attached hereto.

4. That the original of the records was made at or near the time of the act and/or event recited therein by or from information transmitted by a person with knowledge in the course of a regularly conducted activity of the deponent, or the office or institution in which the deponent is engaged.

[✓] Medical Records [✓] Billing Records [ ] Radiology [ ] Other

OR

5. [ ] That the Deponent has found no records/materials.
   a. [ ] This person cannot be located after a thorough search of our files
   b. [ ] have been destroyed/purged. Records/Materials are maintained for ____ years.
   c. [ ] were lost, misplaced, stolen, or damaged beyond repair
   d. [ ] no records for dates specified of : _____
   e. [✓] other : NONO X-RAYS/
   f. [ ] no radiology or [ ] located at another facility : _____

CUSTODIAN SIGNATURE

SUBSCRIBED AND SWORN to before me this 28 day of MARCH, 20 17

NOTARY PUBLIC in and for the said COUNTY and STATE

My Commission expires Feb. 26, 2018

MAYRA L. ROBLES MONTOYA
Notary Public State of Nevada
No. 14-13495-1
My Appt. Exp. Feb. 26, 2018

JS479

VALLEY VIEW SURGERY CENTER (VVSC) PATIENT REGISTRATION

Patient Information:

Name	Birthdate	Age	Sex	ACCT#
JOYCE P SEKERA	03/22/56	61	F	153654

Address	Race	Social Sec #	Marital Status
7840 NESTING PINE PL Las Vegas, NV 89143	Unknown	091488430	S

Home Phone: (702)467-5457 Cell Phone:
Employer: brand vegas Work Phone:

Guarantor: SEKERA, JOYCE P Patient's Relationship: Self
Address: 7840 NESTING PINE Las Veg NV 89143 Phone: (702)467-5457

Primary Insurance:

Carrier: LIEN PAYER Insured: SEKERA, JOYCE
Claims: ATTY; KEITH GALLIHER Patient's Relationship: Self Sex: F
Address DOB: 03/22/1956 SS#: 091-48-8430
1850 E. SAHARA #107 Insurance ID: 00000000000 Group #:
Las Vegas, NV 89104 Auth #:
Ins. Phone: (702)735-0049 Employer: brand vegas

Secondary Insurance

Carrier: Insured: ,
Claims: Patient's Relationship: Sex:
Address DOB: SS#:
Insurance ID: Group #:
Auth #:
,
Ins. Phone: Employer:

Date of Surgery: 11/30/2017 Surgeon: TRAVNICEK, KATHERINE, M.D.

Procedure: BIL L5-S1 RFTC RHI Type of Service: Pain Management LUMB
PreOp DX:

Authorization for Treatment: I hereby authorize treatment at Valley View Surgery Center. I hereby authorize and permit VVSC to release medical billing data relating to this service.

Financial agreement and assignment of payment/benefits: I understand that I am financially responsible for all charges incurred, regardless of insurance coverage. I hereby verify that the insurance information that I have provided, as listed above is correct and that VVSC will bill my insurance for services received. I hereby assign payment of all surgical and/or medical benefits payable on my behalf to VVSC for services at VVSC. I understand that my patient responsibility that is calculated and/or collected on this date is an estimate. The final calculation of my financial responsibility is determined by the insurance company when the claim is processed. Any balance is due within 30 days of billing to patient from VVSC. In the event my account is referred to a collection service due to lack of payment on my part, I acknowledge that there may be additional collection/legal fees added to my account.

Return check charge: I understand that if payment by check is returned unpaid by my bank for insufficient funds (NSF), there will be a NSF fee of $35.00 charged to my account. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

Signed: _____ **Date:** 11-30-17

Relationship if other than patient: _____

Witnessed by: _____

JS480

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: November 30, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: The patient is s/p diagnostic facet joint / facet nerve injections from which she noted significant but transient improvement. The patient is an appropriate candidate for radiofrequency ablation.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT RADIOFREQUENCY RHIZOTOMY BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, insulated radiofrequency needle(s) were inserted percutaneously and directed to the lateral base of the superior articulating process corresponding to the location of each nerve to be lesioned. Needle position was verified in multiple fluoroscopic views. Each nerve was stimulated at 2 hz (motor) to verify needle proximity to the medial branch to be lesioned. Next, each nerve was stimulated at 2 hz 2 volts rule out major motor stimulation. Prior to lesioning, each nerve was anesthetized. Each nerve was then lesioned. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Fentanyl Midazolam
NEEDLE: 18g RF insulated Venom
LESION: 80 degrees C for 90 seconds for one lesion each side
INJECTATE (each site): Bupivicaine (pf) 0.5% final concentration. 1 ml injected into each site.

Copy to: Andrew Cash MD

Electronically signed by KATHERINE TRAVNICEK Date: 11/30/2017 Time: 14:38:19

JS481

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

SCHEDULED PROCEDURE: Bilat LS-SI RFA

CHIEF COMPLAINT/ REASON FOR PROCEDURE:

- ☐ Head pain
- ☐ Neck pain
- ☐ Upper extremity pain
- ☐ Mid back pain
- ☑ Low back pain
- ☐ Sacral pain
- ☐ Lower extremity pain
- ☐ Other: _____

MEDICAL HISTORY: ☐ Other _____

See Pre-Anesthesia Record

Current medications – see Patient Home Medication List (Medication Reconciliation List)

HISTORY OF PREVIOUS PAIN MANAGEMENT PROCEDUDRE:

- ☐ No
- ☑ Yes

Justification for repeat Epidural Steroid Injection

- ☐ Partial Improvement
- ☐ Transient Improvement
- ☐ Significant Improvement
- ☐ Return of symptoms
- ☐ Persistent symptoms
- ☐ Other _____

SOCIAL/ FAMILY HISTORY:

- ☑ Non Contributory
- ☐ Other: _____

ALLERGIES or ABNORMAL DRUG REACTIONS: ☒ NKA ☐ _____

PHYSICAL EXAM:

Heart/Cardiac _____

Lungs/Respiratory _____

Other _____

PLANNED ANESTHESIA:

- ☐ Anesthesiologist.
- ☑ VVCS-RN ASA Score: ☐1 ☒2 ☐3 ☐4

PRE-OPERATIVE DIAGNOSIS:

☑ Spondylosis (facet pain)	☐ Cervical	☐ Thoracic	☑ Lumbar
☐ Spondylosis w/o myelopathy	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Displacement of intervertebral disc	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Degeneration Disc Disease	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Post Laminectomy Syndrome	☐ Cervical	☐ Thoracic	☐ Lumbar

☐ Other: _____

ABNORMAL FINDINGS TO BE ADDRESSED ON DATE OF SERVICE PRIOR TO PROCEDURE: ☐ NA

_____ MD'S Signature ☐ Proceed ☐ Cancel procedure

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia. The Patient is cleared for procedure in VVSC.

DISCHARGE NOTE:

Complications ☑ None ☐ Other: _____

Condition Stable: ☑ Discharge to home

Physician signature: _____

JS482

Valley View Surgery Center

Pain Management History & Physical

Patient Name: **Patient Label**

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

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11/30/17
1130
JS

Date / Nurse Notation:	STANDING ORDERS
	PRE-OP ORDERS: Admit to Valley View Surgery Center for scheduled procedure on consent.
	1. Urine pregnancy test on females having periodic menstrual cycles unless post hysterectomy or no menstrual period for more than a year. Results of Pre-Op blood or urine tests completed 7 days or less prior to procedure will be accepted for pregnancy screening.
	2. Obtain BP, Blood Sugar and HCG results (if applicable) on patients prior to having the patient change for the procedure.
	3. Do blood glucose level on all diabetic patients. Report results greater than 150.
	4. Insert 20G IV cath for Saline lock or IV solution. Flush w/ 3 mls 0.9% NS PRN. May use 0.5% Lidocaine 0.1-0.2mls subcutaneous before insertion. Start IV 0.9 NS 250 mls KVO on non-operative side for cervical procedures.
	5. -Discograms: Ancef 1900mg IVP/IVPB (Ancef 2900mgs IVPB for patients 120kg or greater) -Hardware Blocks, Implants, Plexus Block, Pump Refills, Superior Hypogastric Block, †TSCS and patients with history of MVP, and Subacute Bacterial Endocarditis: Clindamycin 900mg IV.
	7. For cervical transforaminal injections, give Ondansetron (Zofran) 4mg IVP over two to 5 minutes.
	8. For Stellate Ganglion and Sympathetic injections, record a baseline temperature on appropriate bilateral extremities.
	9. Document the date patient discontinued any of the following medications. Acceptable days of discontinuance from date of procedure: [ ]ASA–7days, [ ]Coumadin or [ ]Plavix- for7 days, [ ] Except for Celebrex, all non-steroidal anti-inflammatory medications for 4 days. Inform MD if days do not meet criteria.
	10. For blood patch procedures: Using sterile technique, insert at minimum a 20G IV catheter (preferable 18G) in the antecubital vein as the second IV site for blood draw
	Surgical Consent to read (CHECK ALL THAT APPLY):

CERVICAL ---------- [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection) ***
[ ] Stellate Ganglion [ ] Radiofrequency [ ] Discography [ ] Greater/Lesser Occipital
LEVELS: [ ]C2 [ ]C3 [ ]C4 [ ]C5 [ ]C6 [ ]C7 [ ]C8 [ ]C1-2 [ ]C2-3 [ ]C3-4 [ ]C4-5 [ ]C5-6 [ ]C6-7 [ ]C7-T1

THORACIC ---------- [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)*** [ ] Radiofrequency [ ] Discography
LEVELS: [ ]T6 [ ]T7 [ ]T8 [ ]T9 [ ]T10 [ ]T11 [ ]T12 [ ]T6-7 [ ]T7-8 [ ]T8-9 [ ]T9-10 [ ]T10-11 [ ]T11-12 [ ]T12-L1

LUMBAR ---------- [ ] Left [ ] Right [✓] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)***
[ ] Sympathetic [✓] Radiofrequency [ ] Discography [ ] Caudal/Catheter Directed [ ] Sacroiliac Joint
LEVELS: [ ]L1 [ ]L2 [ ]L3 [ ]L4 [ ]L5 [ ]S1 [ ]S2 [ ]L1-2 [ ]L2-3 [ ]L3-4 [ ]L4-5 [✓]L5-S1
[ ] **OTHER:** [ ] †TSCS [ ] _____
[✓] **UNDER FLUOROSCOPY** †TSCS Trial Spinal Cord Stimulator
*SNRB=Selective Nerve Root Block **TFESI=Transforaminal Epidural Steroid Injection ***MBB=Medial Branch Block

Noted M 11/30/17

INTRAOPERATIVE ORERS: Oxygen at 2-4 L/NC **CONSCIOUS SEDATION** [✓] Versed 4 mg [ ] Attentanil _____ mcg 1200
[ ] Propofol _____ mgs [✓] Fentanyl 150 mcg [ ] Romazicon _____ mg

For Radiofrequency Treatment See RF Neurotomy Procedural Notes Form. Medications drawn up as ordered on MD preference cards.

	PACU ORDERS
	1. Check vitals every 5 minutes x 2 then up to chair/dangle with 1 set of vitals. Record post-procedure temperature readings on patients who received Stellate Ganglion and Sympathetic injection procedures. If local infiltrate and no sedation performed, take vital signs x1. Discharge when patient stable.
	2. For Stellate Ganglion and Sympathetic injections, record temperature on appropriate bilateral extremities.
	3. Oxygen nasal prongs or mask to as needed to maintain pre-op oxygenation level.
	4. Ice chips or liquids as tolerated. Ondansetron 4mg IVP/IM for nausea or vomiting prn.
	5. Do blood sugar testing if pt. received treatment for blood sugar level.
	6. Remove IV catheter just before discharge.
	7. Resume all prior medications. [ ] NA
	8. Resume all anticoagulants on next scheduled dose after the procedure. [ ] NA
	9. Provide and review written copy of post procedure instructions with patient & family members.
	10. Pt may be discharged in 1 hr if post-reversal agent. [ ] yes [ ] no
	11. Other orders:

PHYSICIAN'S SIGNATURE: _____ **JS483**

VALLEY VIEW SURGERY CENTER
Standing Orders - K. Travnicek, M.D.

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

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PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: November 30, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: The patient is s/p diagnostic facet joint / facet nerve injections from which she noted significant but transient improvement. The patient is an appropriate candidate for radiofrequency ablation.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT RADIOFREQUENCY RHIZOTOMY BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, insulated radiofrequency needle(s) were inserted percutaneously and directed to the lateral base of the superior articulating process corresponding to the location of each nerve to be lesioned. Needle position was verified in multiple fluoroscopic views. Each nerve was stimulated at 2 hz (motor) to verify needle proximity to the medial branch to be lesioned. Next, each nerve was stimulated at 2 hz 2 volts rule out major motor stimulation. Prior to lesioning, each nerve was anesthetized. Each nerve was then lesioned. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

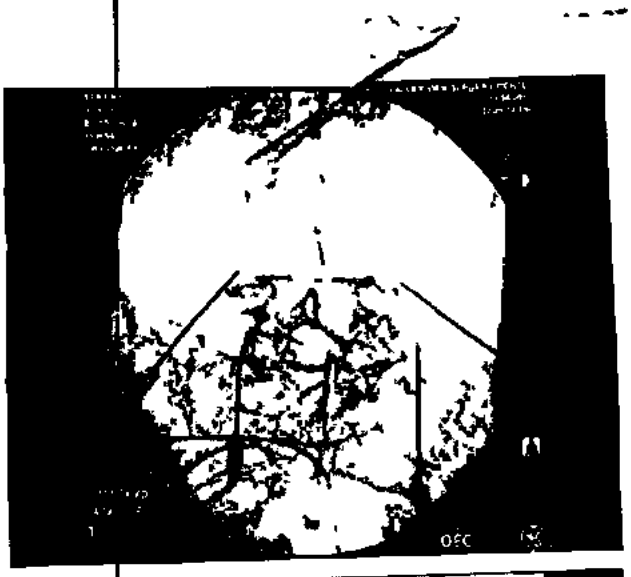
SEDATION (medications titrated to effect): Fentanyl Midazolam
NEEDLE: 18g RF insulated Venom
LESION: 80 degrees C for 90 seconds for one lesion each side
INJECTATE (each site): Bupivicaine (pf) 0.5% final concentration. 1 ml injected into each site.

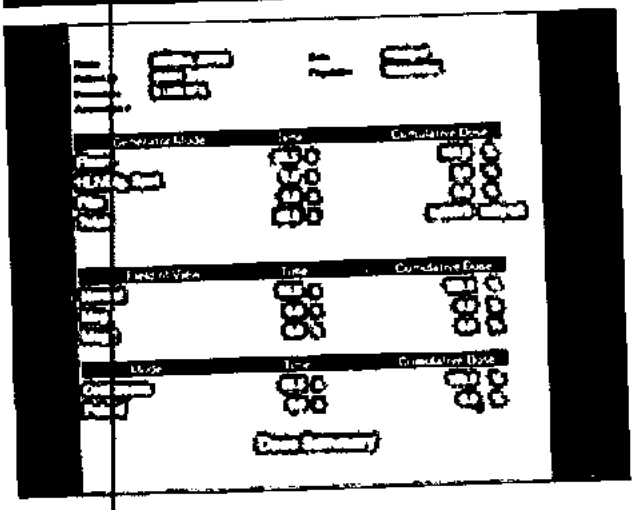
Copy to: Andrew Cash MD

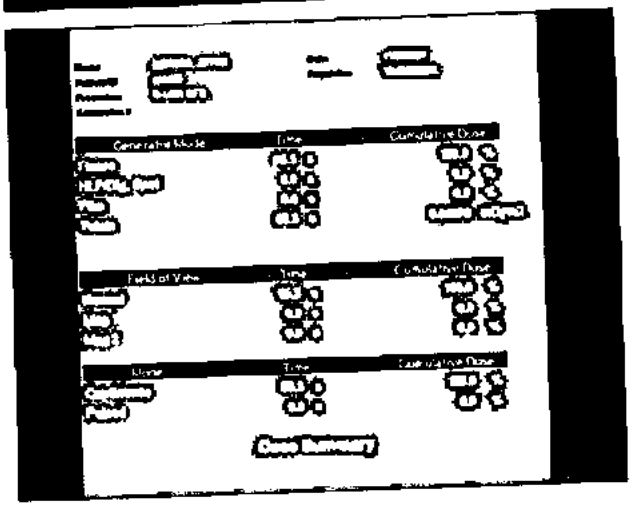
Electronically signed by KATHERINE TRAVNICEK Date: 11/30/2017 Time: 14:38:19

JS484

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F







NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

JS485

Valley View Surgery Center

Patient label

NAME: SEKERA, JOYCE P

Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure.	Greet patient, check two patient identifiers and verify operative site, allergies and other pertinent information. Safety straps applied, patient positioned appropriately with good body alignment and pressure points padded.	Operative site, correct patient and permanent history verified, Allergies noted. Patient encouraged to ask questions about care in the operating room. Proper body alignment and safety straps used. Electrical equipment checked and ensured to be in safe condition.	Initials:

ALLERGIES: ☑ NKA ☐ See Front of Chart

ORPX # 1 Time in TX: 1153 "TIMEOUT" by LW @ 1157 w/MD and all listed staff present

Time PROCEDURE BEGAN: 1201 Time PROCEDURE ENDED: 1217 TIME PT LEAVING TX 1230

If STAGED in room or change in position/different site area:

"TIMEOUT" by _____@_____w/MD and all listed staff present

Time PROCEDURE BEGAN: _____ Time PROCEDURE ENDED: _____ TIME PT LEAVING TX _____

PAIN MANAGEMENT PERSONNEL

DR. PERFORMING PROCEDURE: Dr. K. TRAVNICEK ANESTHESIA: ☑ IVCS ☐ MAC ☑ LOCAL INFILTRATE ☐ GENERAL ☐ OTHER

☐ ANESTHESIOLOGIST ☑ IVCS NURSE A. BUTLER, RN CIRCULATOR C-CHUA, RN

MED NURSE V. PIZANA, RN ☐ N/A SCRUB R. REYES, CST X-RAY M. PASSMANDING OTHER _____

MEDICATIONS GIVEN BY PHYSICIAN DURING THE PROCEDURE:

☐ 1% Lidocaine MPF ☑ 0.5% Bupivacaine MPF ☐ 0.9% Normal Saline ☐ Omnipaque 300 mg plain

☐ 2% Lidocaine MPF ☐ Dexamethasone ☐ Myoblock ____Units ☐ Omnipaque 300 mg Added ☐ Ancef ____mg

☑ 4% Lidocaine MPF ☐ Methylprednisolone ☐ Pump medication verified with attending MD

(The dose and route of the medications given are noted on the procedural report of the physician performing the procedure.)

PRE-OP DIAGNOSIS: Lumbar Spondylosis

PROCEDURE: [ ] Cervical [ ] Thoracic [✓] Lumbar [ ] Caudal [ ] Hip [ ] Knee [ ] Shoulder (Number multiple procedures in sequence)

[ ] Discography

[ ] Epidural Steroid Injection

[ ] Facets: [ ] Right [ ] Left [ ] Bilateral

[ ] Intercostal Nerve Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Medial Branch Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Occipital, Greater/Lesser: [ ] Right [ ] Left [ ] Bilateral

[✓] Radiofrequency: [ ] Right [ ] Left [✓] Bilateral See RF Neurotomy Procedural Notes Form

[ ] Sacroiliac Joint: [ ] Right [ ] Left [ ] Bilateral

[ ] Selective Nerve Root Block: [ ] Right [ ] Left [✓] Bilateral

[ ] Stellate Ganglion: [ ] Right [ ] Left [ ] Bilateral

[ ] Sympathetic Block, Lumbar [ ] Right [ ] Left

[ ] Transforaminal epidural steroid injection: [ ] Right [ ] Left [ ] Bilateral

[ ] Trial Spinal Cord Stimulator [ ] Trial Pain Pump [ ] Other _____

Prep to operative site: ☐ Duraprep ☑ Chloraprep: ☐ Tinted ☑ Clear By: R. Reyes, CST

Positioning: ☐ Supine ☑ Prone ☐ Lateral ☐ Arms tucked ☑ Pillows for positioning

☐ Padded toboggans used for arm protection ☑ Safety strap on x 3

POST OP DIAGNOSIS ☑ SAME ☐ Other _____ ☐ Pain log given

Notes: _____

☑ Radiation Skin Status - Pre Radiation ☑ All Clear Post Radiation ☑ All Clear

CIRCULATOR SIGNATURE C-Chua

JS486

Patient Label

Valley View Surgery Center

Pain Management OR Record

Dr. K. Travnicek

NAME: SEKERA, JOYCE F

ACT#: 153654

DOB: 03/22/56 AGE: 61

DR: TRAVNICEK, KATHERINE M.D.

DOS: 11/30/17 SEX: F

M:\FORMS\Clinical forms\Pain Mgmt OR Record\017 Pain Mgmt OR Record Travnicek rev120816pp.doc

Radiofrequency Neurotomy Procedural Form

Grounding Pad: ☑ Right ☐ Left / ☑ Thigh (posterior) ☐ Calf Lot#: 2020-03DC Exp.: 2020-03

Grounding pad site post-procedure: ☑ Clear ☐ See comments

Equipment used: ☐ Baylis Medical Radiofrequency Generator ☑ Stryker RF Multi-Generator

Side		Level	Min Sensory	Max Motor	RF Cannula Gauge	RF Cannula Length	RF Cannula Tip	Burn 1 Imped (Ohms)	Burn 2 Imped (Ohms)	Burn 3 Imped (Ohms)
[ ]L	[ ]R	L5	✓	2.0	18mm	100mm	10mm	☒ 194	[ ]	[ ]
[ ]L	[ ]R	S1	✓	↓	↓	↓	↓	☒ 240	[ ]	[ ]
[ ]L	[ ]R	L5	✓	↓	↓	↓	↓	☒ 262	[ ]	[ ]
[ ]L	[ ]R	S1	✓	✓	↓	✓	✓	☒ 195	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
[ ]L	[ ]R							[ ]	[ ]	[ ]
WNL = Within Normal Limits (per manufacturers guidelines)								[x]WNL	[x]WNL	[x]WNL

BURN 1
Settings: ☑ Auto Temp ☐ Auto Pulsed Temp: 80 degrees Celsius Time 90 seconds

BURN 2
Settings: ☐ Auto Temp ☐ Auto Pulsed Temp: _____ degrees Celsius Time _____ seconds ☐ Same as Previous

BURN 3
Settings: ☐ Auto Temp ☐ Auto Pulsed Temp: _____ degrees Celsius Time _____ seconds ☐ Same as Previous

Comments: Venom needles

Recording RN Ane Chua RF Operator _____ ☒ same

JS487

VALLEY VIEW SURGERY CENTER

RF Neurotomy Procedural Notes

M:\FORMS\Clinical forms\RF Procedural Note Sheet.edited rev011514 SS.doc

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

Pre-OP Vitals BP 152/60 HR 52 RR 14 O_2 Sat 96 % ☑ Room air ☐ Oxygen @ ___ L/min Temperature 96.2 °F

ALLERGIES ☑ NKA ☐ See Front of Chart

	Time	1155	1156	1202	1203	1204	1208	1209	1214
Legend: v = Systolic BP, ^ = Diastolic BP, • = Pulse	220								
	210								
	200								
	190								
	180								
	170								
	160								
	150								
O_2 Appliance: ☑ Cannula ☐ Mask	140								
O_2 Liter Flow @ 2 L/min	130								
ECG: ☑ NSR	120								
☐ Sinus Bradycardia	110								
☐ Sinus Tachycardia	100								
☐ Other:	90								
IV Site: ☑ Right arm	80								
☐ Left arm	70								
☐ Other:	60	^	^		^	^		^	^
Condition: ☑ Patent	50								
☐ Other:	40	•	•	•	•	•	•	•	•
Solution: ☑ Saline Lock	30								
☐ Isolyte ☐ 0.9% NaCl	SaO_2	100	100	100	100	100	100	100	100
☐ Other :	RR	16	12	16	16	16	16	16	14
Acceptable range 35-45mmHg	ETCO2								
ETCO2 Waveform present ✓		✓	✓	✓	✓	✓	✓	✓	✓
CONSCIOUS SEDATION SCALE									
Respirations: 0. Appear Adequate 1. Impaired exchange 2. Dyspnea/Obstructed		0	0	0	0	0	0	0	0
Level of Consciousness: 0. Alert or awakening 1. Follows commands / Intermittent arousal 2. Unresponsive		0	0	0	1	1	1	1	1
Vital Signs 1. Increase (>20% of pre-anesthetic level) 2. Within acceptable limits 3. Decrease (>20% of pre-anesthetic level)		2	2	2	2	2	2	2	2
Physical/ Emotional Affect: 0. Resistive / Tense / Anxious / Uneasy 1. Tempered or Intermittent response/ Calm / Tolerant 2. No response		1	1	1	1	1	1	1	1
Total Sedation scale (Optimal 3-5)		3	3	3	4	4	4	4	4
MEDICATIONS		D	O	S	A	G	E	S	
☑ Versed IV mg		2		1		1			
☑ Fentanyl IV mcg		100			50				
☐ Alfentanil IV mcg									
☐ Propofol IV mg									
☐ Romazicon IV mg									
☐ Narcan IV mg									
☐ Cefazolin IV mg									
☐ Other:									

IVCS RN Printed Name: M Beeler **Signature:** _____ **Initials** ly

Antibiotic: ☒ NA M. Beeler **completed at** _____ **by** _____

☑ Patient tolerated procedure well and was transferred to PACU in apparent good condition.

☑ Report given by IVCS/circulating nurse and care handed over to **PACU Nurse** K. Yong, RN

VALLEY VIEW SURGERY CENTER
IVCS by RN

Patient Label

NAME: SEKERA, JOYCE P JS488
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

M:\FORMS\Clinical forms\017A IVCS by RN.doc rev 100413 fd

Nursing Diagnosis	Outcome/Goal	Plan	Interventions/Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure	Ensure immediate , on-site availability of back-up personnel for airway management, resuscitative emergency intubation and emergency equipment	Emergency equipment will be present, working properly and immediately available in the room where the procedure(s) are performed Nursing assessment conducted by IVCS nurse including pertinent medical history, verification of allergies, confirmation of NPO status	
Potential decrease in blood pressure, heart rate, peripheral resistance and oxygen saturation, especially during administration of sedation agent(s)	Patient vital signs will remain within patient's normal limits as evident by the utilization of monitoring equipment peri-operatively	Explain monitoring equipment and ECG pads to patient	ECG electrodes, blood pressure cuff and pulse oximeter applied prior to procedure Vital signs will be monitored continually throughout the procedure at a minimum before the start of procedure, one minute after administration of medication(s) given, and at least every five minutes thereafter until procedure is completed	
Potential for anxiety and pain related to therapeutic and/or diagnostic procedures	Patient will be able to tolerate diagnostic and/or therapeutic procedures with reduced anxiety and discomfort. Patient's LOC will be mildly depressed with an altered perception to pain, but will retain the ability to respond appropriately to verbal and/or tactile stimulation	Sedation agent(s) will be administered per physician's orders	Pts LOC will be assessed at regular intervals, verbal reassurance will be given to divert patient's attention and assist in reducing anxiety	Initials:

Date: 11/30/17 Monitors On ☑ Alarms Set ☑ Allergies: ________ ☑ NKA

Procedure: Radiofrequency nerve ablation of bilat Lumbar 5–Sacral 1

PreOp: B/P 152/59 Pulse 52 RR 16 SaO₂ 98 % ☑ RA ☐ @ ___ L/min Temp: 96.2 Pain Level: 3 Initials Q

ADMIT TIME	BP	[illegible]	[illegible]	O2 SAT O2 L	RA	[illegible]	PAIN LEVEL	POST ANESTHESIA ASSESSMENT RECOVERY SCORE	[illegible]	[illegible]
1220	143/66	48	16	95		98.9	Ø	Purposeful movement of all extremities =2 Moves two extremities =1 Activity No movement of extremities =0	Ø	2
1225	159/76	48	16	95			Ø			
1230	127/73	49	16	94	RA		Ø	Breath deeply and cough freely =2 Limited and/or impaired breathing =1 Resp Apnea =0	2	2
1235	142/71	53	18	94	RA		Ø			
								BP stable or improved over PreOp readings. Pt. asymptomatic = 2 Pt. outside of acceptable range based on PreOp readings. =1 Circ Unstable Hypotension or Hypertension = 0	2	2
								Alert, fully awake, responding appropriately =2 Responds to name and/or verbal stimuli =1 LOC Unresponsive =0	Ø	2
								Normal skin color/SpO₂ > 92% on room air = 2 Pale, Supplemental O₂ for SpO₂ > 90% =1 Color SpO₂ < 92% with O₂ supplementation =0	1	2
								Totals:	5	10
								DISCHARGE CRITERIA: SCORE 10 or pre-anesthesia		(10)

TIME	MEDICATION/DOSE/ROUTE/SITE [illegible]	[illegible] PAIN LEVEL	INITIALS

NURSES NOTES [illegible]

AN13 1245 legs weakness unsteady gait. Instructed to leg exercises. Pt demonstrated understanding — any
1301 Lanisha checked on pt. Pt's legs still unsteady & weak — any
1346 OT Lanisha saw pt. Pt's leg still unsteady & weak. Continue c leg exercises. Lanisha spoke to pt's mother — any
1425 Pt ambulate c steady gait — any

☐ Pt. given pain log and understands instructions as noted by pt.'s verbalization. ☑ NA

☑ Time: 1245 Pt. up in wheelchair. Medically discharged. Waiting for ride.

Signature	Qny	Initials	Any
Signature		Initials	

DISCHARGE

Pt. tolerated procedure without apparent injury: ☑ Yes ☐ No*
Safety maintained: ☑ Yes ☐ No*
LOC: ☑ Alert ☐ Oriented same as PreOp level ☐ Sedated* ☐
Nausea ☐ Vomiting ☑ N/A ☐ Minimal/Not treated ☐ Treated
Intake: PO 100 mls IV ø mls
Discharge Criteria Met: ☑ Yes ☐ No*
IV catheter removed / catheter intact: ☑ Yes ☐ No*
S/S of complications due to IV: ☑ No ☐ Yes*
Copy of discharge instructions given to pt./other: ☑ Yes ☐ No*
Prescription given: ☑ NA ☐ Yes If yes, instructed pt. to take medication as written on prescription ☐ Yes ☐ No
Instructed pt. to resume medications as instructed / ordered by MD. ☑ Yes ☐ No
Pt./other states understanding of all instructions: ☑ Yes ☐ No*
Mobility unchanged from Pre Op level: ☑ Yes ☐ No*
Supplies given at discharge: ☑ NA ☐ Yes
Discharged via w/c to responsible adult: ☑ Yes ☐ No*
Discharge Pain Level: ø Discharge Time: 1426

VALLEY VIEW SURGERY CENTER

POST PROCEDURE RECORD

Patient Label

JS490

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

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POST-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Altered airway Function Post-anesthesia	• Observe & maintain or support airway as needed • O_2 on arrival / PRN • Monitor SaO_2 • Appropriate position	Patient airway with maximum respiratory compliance as evidenced by adequate O_2 exchange, tissue perfusion & visible hemodynamics. Clear airway without aid/at	Goal is obtained: ☑ Yes ☐ No Comments:
Altered hemodynamics potential for hypovolemia	• Monitor EDG for arrhythmia • Note/intervene for B/P +/- 50% of pre-op reading • Observe surgical site for bleeding	Stable hemodynamics	Goal is obtained: ☑ Yes ☐ No Comments:
Altered level of consciousness	• Stimulate adult patient PRN • Do not stimulate pediatric patient if airway & hemodynamics are stable • Orient patient to surroundings • Observe for altered L.O.C.	Patient will be arousable, oriented and as alert as possible prior to discharge	Goal is obtained: ☑ Yes ☐ No Comments:
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety. Able to verbalize pos-op instructions (i.e. diet, wound care, pain control & activity)	Goal is obtained: ☑ Yes ☐ No Comments:
Potential injury	• Utilize side rails (pads PRN) • Place bed in low position • Secure IV's and assess for patency • Ensure correct physiological positioning	No injury in PACU	Goal is obtained: ☑ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Relief of pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments: AHY
Nausea & Vomiting ☑ N/A	• Recognize nausea • Medicate as ordered • Teach relaxation techniques • Position for comfort & to prevent aspiration	Relief of nausea verbalized	Goal is obtained: ☑ Yes ☐ No Comments:

Initials of Nurse AHY

Nurses Notes Continued as needed:

If EKG strip affixed to record, complete the following:

Time _____ am/pm

Dr. _____ notified @ _____ am/pm

Per MD's order: ☐ No treatment
☐ Treatment: _____

Signature of RN: _____ Time: _____ am/pm

Date: 11/30/17 Time Admitted: 1130 **PRE-OP CHECKLIST** few sips of water

Pt. identified by ☑ full name ☑ date of birth by ☑ ID From: ☐ Home ☐ Other _____ Via: ☐ Walking ☐ Wheelchair ☐ Carried

Planned Procedure: Bilat L3-S1 RFA NPO since: 0400 AM Meds: ☐ Yes ☑ No

Responsible Adult taking pt. home: James /Driver: Neighbor ☐ Same ☐ Waiting ☐ Call at: 6192065163

MEDICAL HISTORY: ☐ Asthma ☐ Ulcers ☐ Hiatal Hernia ☐ TMJ ☐ SOB ☒ Diabetes ☐ MVP ☐ Stroke ☐ Sleep Apnea ☐ Hepatitis
☐ Hypertension ☒ Smoker ☐ Chest Pain/Previous MI (Date _____) ☐ Palpitations ☐ Seizures ☒ Back/Neck Problems
☐ Thyroid Problems ☐ AIDS/HIV Positive ☐ Street Drugs ☒ Arthritis ☐ Osteoporosis ☐ Other/Notes: _____

SURGICAL HISTORY: ☐ Tonsils/Adenoids ☐ Gallbladder ☐ Hysterectomy ☐ CABG ☐ Hernia ☐ Appendix ☐ Back ☐ Hip
☐ Sinus/Nasal ☐ Biopsy _____ ☐ D&C ☒ Laparoscopy ☐ Metal Implants ☐ Pacemaker/ICD ☐ Foot ☐ Cervical
☐ Knee ☐ Eye Surgery ☐ Other/Notes: C-Section

Medication list: See Pre-Anesthesia Record and Patient Home Medication List

VITAL SIGNS: Weight 93 kg Height 5'6 BMI 33.9
SaO_2 96 % ☒ RA @ _____ L/min Temp 96.2 Pulse 52 Resp 16
BP 107/59 ☐ R ☐ L arm Extremity temp: R _____ L _____ ☐ NA

ALLERGIES: ☒ NKA _____

☐ See Front of Chart

SYSTEMS ASSESSMENT ☐ = Fall Risk If ☐* 1 or ≥ 2 checked, ☐ Fall Risk Band applied
☐** Patient undergoing lumbar procedure

Respiratory:
Respiration: ☐ unlabored ☐ labored ☐ other _____
Breath Sounds: ☐ audible ☐ clear ☐ other _____
Cough: ☐ absent ☐ non-productive ☐ productive ☐ other _____

Cardiovascular:
Heart tones: ☐ regular ☐ irregular ☐ other _____
Color: ☐ pink ☐ cyanotic ☐ other _____

Neuro Sensory:
☐ alert ☐ oriented ☐ confused ☐ other _____

Psychosocial: ☐ calm ☐ anxious ☐ crying ☐ angry ☐ other _____

Skin: ☐ normal ☐ pink ☐ cyanotic
☐ warm ☐ cool ☐ dry ☐ diaphoretic ☐ other _____

GI / GU: ☐ normal ☐ incontinent ☐ other _____

Activity: ☐ full ☐ ROM ☐** uses assistive device ☐** fall within 3 mo ☐ other _____

***Pain Intensity Level:** 3/10 Location: lower back Pain Quality dull ache

CHECKLIST	Yes	No	NA
Consent	✓		
H&P	✓		
H&P (Podiatry)			✓
CXR			✓
EKG			✓
CBC			✓
Coag.			✓
Urine			✓
Lytes/Chem panel			✓
Preg Urine/Serum			✓
Hepatitis Screen			✓
HIV			✓
Medical Clearance			✓
Surgical Site Clipped			✓
TEDs/SCDs			✓
Bowel prep finished			✓

PREMEDICATIONS:

Times	Medication / Dose	By

PreOp teaching ☑ Yes ☐ No
Discharge inst. given ☑ Yes ☐ No
Patient ride confirmed ☐ Yes ☐ No

Valuables w/	Patient	Family	None
Dentures	upper		
Glasses/Contacts			✓
Hearing aids			✓
Clothes	✓		
Jewelry/ Body Jewelry	*See back		✓

If no, how much was taken? ☐ 1/4th ☐ 1/2th ☐ 3/4th

TESTING ON UNIT	RESULTS	N/A
Urine Visual Pregnancy	Neg 0606	✓
AccuChek ☑ FBS ☐ RBS	91	
Range FBS 70 – 200 mg/dL: Notify MD according to standing orders or greater than 200mg/dl		

Procedure or surgery site:
☐ Confirmed w/pt.: ☐ right ☐ left ☐ bilateral ☐ NA
☐ Marked by MD
IV started in holding: ☐ Yes, Number of Attempts 1 Initials JD

Flush: ☒ 5 mls NS ☐ IV _____ ☐ _____ mls
Site: ☒ R ☐ L ☒ Superior Dorsal ☐ Antecubital vein
☐ Other: _____ Gauge ☐ 18 ☒ 20 ☐ 22 ☐ 24 Exp: 08/20
ID band applied by: JD
☒ Pt. tolerated tx. ☐ Other _____

SIGNATURES (Initial)
JD _____ (JD)
( )

To OR via: ☐ gurney ☐ side rails up ☐ bed ☐ low
☐ carried ☒ walk in

JS492

Valley View Surgery Center
PRE-OP CHECKLIST
M:\FORMS\Clinical forms\PRE OP CHECKLIST rev 072217 fd.doc

Patient Label
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

PRE-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety	Goal is obtained: ☐ Yes ☐ No Comments: _____
Potential injury	• Utilize side rails (pads PRN) • Place bed in low position/chair locked • Secure IVs & assess for patency • Ensure correct physiological positioning	No injury in Pre-Op	Goal is obtained: ☑ Yes ☐ No Comments: _____
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments: _____

Pre-Op Nurse initials _____

NURSE'S NOTES

*Confirmed/witnessed with pt.: jewelry secured in closed plastic bag. Bag placed in pt.'s belonging bag.

Nurse's Initials _____

**See BMI chart

TIME	

Reference: AAAHC Institute for Quality Improvement, *Patient Safety Toolkit: Ambulatory Surgery and Preventing Falls*, 07/22/13

Height / Estatura 5'6" Actual Weight / Peso ~~202~~ 205 lb.

Allergies / Alergias: NKA

1. **Have you taken any of the following medications:**
   Ha tomado los medicamentos listados:

Aspirin: ☐ **Yes, date last taken** / Aspirina: ☐ Si, ultima fecha tomada	_____	☐ No
Plavix: ☐ **Yes, date last taken** / ☐ Si, ultima fecha tomado	_____	☐ No
Coumadin: ☐ **Yes, date last taken** / ☐ Si, ultima fecha tomado	_____	☐ No
Anti-Inflammatory: ☐ **Yes, date last taken** / Anti-Inflamatorios ☐ Si, ultima fecha tomado	_____	☐ No

2. **For female patients only:** **Date of last menstrual period** 2006 ? ☐ N/A
   Para mujeres solamente: fecha de su ultima menstruación_____

3. **List all previous surgeries (and when)**
   Lista de todas cirugías previas (con fechas)
   laparoscopy
   C-section

4. **Do you symptoms of tuberculosis**
   Ha sido diagnosticado con Tuberculosis-

-Productive cough / -Tos productiva	☐ Yes ☒ No	-Weakness, Fatigue / -Fatiga, debilidad	☒ Yes ☐ No
-Bloody sputum / -Esputo con sangre	☐ Yes ☒ No	-Night sweats / -Sudores nocturnos	☒ Yes ☐ No
-Unexplained weight loss / -Perdida de peso inexplicable	☐ Yes ☒ No	-Fever / -Fiebre	☐ Yes ☒ No

HISTORY / HISTORIAL	Yes / Si	No
5. **Have or are you taking "street drugs"** **If yes, last date**_____ Ha o está tomando drogas ilegales En caso que si, fecha ultima: _____	☐	☒
6. **Do you use Medical Marijuana?** **If yes, last date:**_____ Utilizas la marihuana medicinal En caso que si, fecha ultima:_____	☐	☒
7. **Have you had recent weight change? (Significant amount)** Has tenido cambio significante en peso	no	

HISTORY / HISTORIAL	Yes / Si	No
8. **Do you smoke?** **If yes, cigarettes per day:** 3 ¿Fuma? En caso que si, cuantos cigarrillos per día ___	☒	☐
9. **Do you have caps, false teeth, bridge, partials or contact lenses?** upper ¿Tiene dientes falsos, tapas, dentaduras/Puente parsial o lentes de contacto	☒	☐
10. **Do you drink alcoholic beverages?** **If Yes, how much** _____, **last time**_____ ¿Consume bebidas alcolicas? En caso que si, cantidad _____	☐	☒
11. **Have you ever experienced any reaction to rubber or latex products?** Alguna vez ha experimentado una reacción a los productos de goma o látex **If yes, please describe** En caso que si, por favor describa	☐	☒
12. **Glaucoma** Glaucoma	☐	☒
13. **TMJ (dysfunction of temporomandibular joint)** TMJ (disfunción de la articulación temporomadibular)	☐	☒
14. **Stiff neck** Cuello tieso	☐	☒
15. **Shortness of breath** Dificultad para respirar	☐	☒
16. **Asthma** Asma	☐	☒
17. **Heart attack** Ataque de Corazón	☐	☒
18. **Chest pain; angina** Dolor de pecho	☐	☒
19. **Palpitations** Palpitaciones	☐	☒
20. **High blood pressure** Alta presión	☐	☒
21. **Implanted pacemaker/defibrillator** Marcapasos / desfibrilador	☐	☒

CONTINUE ON BACK
CONTINUAR EN LA PARTE POSTERIOR

JS494

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)

M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 61
DOB: 03/22/56 DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

HISTORY HISTORIAL	Yes Si	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☑
23. **Hepatitis** Hepatitis **If Yes /** En caso que si **Type** ☐ A ☐ B ☐ C	☐	☑
24. **Hiatal Hernia** Hernia Hiatal	☐	☑
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** 8/16 ¿En caso afirmativo, cuándo? _____	☑	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☑
27. **Ulcers** Ulceras	☐	☑
28. **Stroke** Derrame Cerebral	☐	☑
29. **Seizures** Convulsiones	☐	☑
30. **Parkinson disease** Enfermedad de Parkinsons	☐	☑
31. **Blackouts** Desmayos	☐	☑
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☑
33. **Back / Neck Problems** Problemas de cuello / espalda	☑	☐
34. **Osteoporosis** Osteoporosis	☐	☑
35. **Muscle Diseases** Enfermedad Muscular	☐	☑
36. **Arthritis** Artritis	☑	☐
37. **Diabetes** Diabetes	☑	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☑
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☑
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☑
41. **Blood Transfusion** Transfusión de sangre	☐	☑
42. **Kidney Disease** Enfermedad de Riñones	☐	☑
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que SI, fecha de ultimo tratamiento?	☐	☑

HISTORY HISTORIAL	Yes Si	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☑
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☑
46. **Metal Implants** dentures Implantes Metálicos	☑	☐
47. **Cancer** **If Yes, Where** _____ Cancer En caso que Si, en donde _____	☐	☑
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☑
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☑
50. **Draining wound** Herida abierta	☐	☑
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☑
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☑

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

_____
Signature (Patient/ or Person filling out form)
(If other than patient, relationship : _____)

Joyce Sekera
Firma (Paciente/representante)
(relación al paciente: _____)

11/30/17
Date/Fecha

[signature]
Signature of Pre Op Nurse

11/30/17
Date

☐ = Fall risk

JS495

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Lal
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

Valley View Surgery Center

PATIENT HOME MEDICATION LIST (As Provided by Patient)

Please fill in bright green areas only and bring form back to VVSC before or on the day of your procedure!

☒ No Known Allergies

ALLERGIES AND THEIR REACTIONS:

List all medications taken over the past 6 months (include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment.)

*Medication Name	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: 11/30/17 Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)
MetFormin	500MG	1 Day	diabetes	11/29			
GaBaPentin	300MG	1 Day	Pain	11/29/2017			
CelecoxiB	200MG	2 Day	PAIN	11/29			

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR

**Pre-Op Nurse Signature * Complete Medication Information Unknown by pt. = CMI Unk	**	**	**	**
	*☐CMI Unk	*☐CMI Unk	*☐CMI Unk	*☐CMI Unk
¥ is PACU Nurse Signature ** ☒Check box if pt/cg instructed on medication use, common side effect, and aftercare upon discharge.	☐ ¥	☐ ¥	☐ ¥	☐ ¥
	☐Copy of med list given to pt. on DC.	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC

********** Contact your prescribing physician for questions regarding any medications listed on this page**********

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

PATIENT LABEL | PATIENT LABEL | PATIENT LABEL

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JS496

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VVSC Surgical/Procedural Safety Checklist

Note: Patient is patient himself/herself or legal representative or surrogate	Pre-Op	OR	PACU
1. Ensure a clean and sanitary environment for each patient.	KD	w	Ady
2. Patient identified as per VVSC policy & ID Band is on patient	KD	w	Ady
3. Allergies/ adverse reactions verified and stated on front of chart	KD	w	Ady
4. MD order(s) for planned procedure documented	KD	w	Ady
5. MD's order for planned procedure is the same as the procedure consent	KD	w	Ady
6. Surgery/Procedure Consent: Operative Procedure & site verified with patient	KD	w	
a. Patient's Signature	KD	w	
b. Witness Signature	KD	w	
7. Anesthesia Consent:	KD	w	
a. Patient's Signature	KD	w	
8. H & P – to include heart and lung (Noted on Pre-Op checklist form)	KD	w	
9. Pre-Op MD Orders	KD	w	
a. As ordered, pre-op test(s): ☐ Completed, results reviewed and placed in chart ☐ Not present, action taken (See pre-op checklist nurse's note) ☒ N/A	KD	w	
b. Standing Orders to draw blood sugar and /or urine pregnancy test ☒ N/A	KD		
c. Actions if blood sugar is out of range. Noted on back of Pre-Op Checklist and in blood sugar result log ☒ N/A	KD		
d. Antibiotic as ordered: ☐ Initiated ☐ Completed ☒ N/A	KD	w	
e. *Any special equipment, devices, implants ☐ Yes ☒ N/A	KD	w	
10. Procedure Site: MD marked Operative site ☐ Yes ☒ N/A	KD		
11. Pre-Op Anesthesia/Nurse Assessment Form / Medication List	KD		
a. Patient Signature	KD		
b. Nurse Signature	KD		
c. Medication list has dosage, frequency, date last taken. If pt. doesn't know, document	KD		
Any G-Codes occurrences? ☒ No ☐ Yes List G-Code_____ See back of sheet	KD		
12. Intra-Op or Intra-Treatment: Ensure a clean and sanitary environment for each patient			
13. Intra Operative briefing before procedure started: *Time-Out* performed per policy, allergy status and other concerns discussed- *difficult airway or aspiration risk or aspiration risk, risk of blood loss if applicable			
14. *Procedure site is marked and visible ☐ N/A			
15. *Relevant images properly labeled and displayed ☐ N/A			
16. *De-briefing after completion of procedure			
a. Name of procedure performed			
b. Sponge, sharp count performed ☐ N/A			
c. Specimens identified and labeled ☐ N/A			
d. *Any equipment problems to be addressed ☐ N/A			
e. *Key concerns for recovery and management of this patient ☐ N/A			

JS497

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

	Pre-	OR	PACU
17. Sterilization Documentation completed/initialed			
18. O. R. Record Complete with out of OR time			
# 12 to #18 completed by			
Any G-Codes occurrences? ☐No ☐Yes List G-Code_____ **See below for references**			
19. Ensure a clean and sanitary environment for each patient			
20. Admit time to PACU			
21. Post Op Orders Noted			
22. Signature of Discharging MD for anesthesia recovery Discharge time on PACU record			
23. Discharge time to home or transfer to hospital noted ☑Yes			
24. Copy of VVSC's prescriptions ☐Yes ☑ N/A			
25. Name of responsible adult pt. discharged to noted on discharge instructions			
26. Phone number of the physician doing surgery or procedure on discharge instructions			
Any G-Codes occurrences? ☑No ☐Yes List G-Code_____ **See below for references**			

Nurse Name: **Printed** L. Carballosa	Signature:	/ Initials:	
Nurse Name: **Printed** Candice Chua	Signature:	/ Initials:	
Nurse Name: **Printed** A. Lapsley	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
RN Co-sign for LPN: **Printed**	Signature:	/ Initials:	

ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE First and last name initials signify the nurse has completed the listed responsibility. "O" with initials next to it signifies the nurse assessed the responsibility and completion is needed.*Revisions/Additions to this form adopted from AORN Comprehensive Surgical Checklist that incorporated WHO, Joint Commission-Universal Protocol (JC) 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	**G8908** Patient documented to have received a burn prior to discharge
Patient Fall	**G8910** Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	**G8912** Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	**G8914** Patient documented to have experienced hospital transfer/admission
Prophylactic IV Antibiotic Timing	**G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
	G8917 Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.

3/10

I consent to the admission to Valley View Surgery Center (VVSC) for my treatment(s) and authorize VVSC, staff, and doctor(s) to provide care. I authorize and direct **DR. TRAVNICEK** to perform the following treatment(s) or any other treatment deemed necessary at the discretion of the physician:

RADIOFREQUENCY NERVE ABLATION OF BILATERAL LUMBAR FIVE-SACRAL ONE MEDIAL BRANCHES WITH THE USE OF FLUOROSCOPIC GUIDANCE

Physicians providing services at VVSC are not agents or employees of VVSC.

I understand I have the right to be informed. My physician has explained the treatment(s) necessary to treat my condition, purpose of the treatment and its associated anticipated benefits, including but not limited material risks, and alternative methods of treatment and its associated anticipated benefits, including but not limited material risks. No guarantee has been given as to the results that may be obtained. I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results. I have the right to be informed of the likelihood of success and the problem(s) associated with recuperation and the possible results of non-treatment. I have the right to request/consent to or to refuse any proposed treatment at any time prior to its performance.

I have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation/procedure. I have the right to be informed if any professional relationship to another health care provider or institution that may suggest a conflict of interest exists.

If applicable, I authorize the administration of anesthesia from an anesthesia provider as may be deemed necessary for the treatment.

My signature below authorizes the pathologist to use his/her discretion in disposing of any tissue removed from my person during the treatment(s) described above. I authorize x-rays, photographs, or videotaping for diagnostic or medical education purposes including utilization of medical residents, students, and/or manufacturing representatives.

I authorize to the drawing of a blood sample from my body in the event that an employee or physician of the surgery center has an accidental puncture or mucous membrane (eye, mouth, etc) exposure to my blood or body fluids. The blood samples will be tested for HIV and Hepatitis. No results of any tests done on my blood will be released or shown to any unauthorized person without my written consent.

My signature on this form indicates that I have read and understand the information provided on this form, that the treatment(s) described above has been adequately explained to me by my physician, that I have had the opportunity to ask questions, that I received the information I desire concerning the treatment, and that I consent and authorize to the performance of the treatment(s) upon myself.

I understand and agree that I am solely responsible for maintaining the privacy of my protected health information in the paperwork I received.

I have not eaten or drank since (Date& Time) 11/30/17 0400 ☐Fluid, ~~2300~~ (am't), ☐Solid 2300
few sips of water
I have a responsible adult to drive me home.

X _____ 11/30/17 1134
Patient's Signature or Patient's Representative or Surrogate — Date — Time
Relationship to Patient: ☑Self ☐Other

_____ 11/30/17 1134
Signature of person witnessing the patient's or patient's legal representative signature — Date — Time

☑ Verified consent _____ Initials of circulator

< SEKERA, JOYCE >

JS499

Valley View Surgery Center

Treatment Consent/Authorization

Addressograph
NAME: SEKERA, JOYCE F
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

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Patient Consent for Anesthesia at Valley View Surgery Center

I understand:
I will need anesthesia services for the surgery/procedure to be done today,

- And the amount of anesthesia to be used will depend upon the procedure(s) and my physical condition. Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical/surgical procedure.
- During the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
- Although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are a part of the risks I must consider in deciding to have a procedure. Some of the unusual risks and complications of anesthesia may include but are not limited to allergic or adverse reactions, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/by others, seizures, sore throat, and death.
- A detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to inform me. No guarantees have been made by anyone regarding the anesthesia services which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS:

Patient Initials	
____	☐ **General Anesthesia:** 1. Mask Anesthesia- Anesthetic gases are passed through a mask which covers the nose and mouth or 2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth or 3. Laryngeal/Mask Anesthesia- Gases are passed through a mask placed behind the tongue which covers the larynx (voice box) or
____	☐ **Deep sedation**
____	☐ **Regional Anesthesia** 1. Nerve block-Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.
____	☐ **Moderate Anesthesia Sedation**-No use of anesthetic gases and no active control of airway/respiration. Passive oxygen and intravenous medication allowed.
____	☐ **Local Anesthesia** 1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedure site. 2. Topical Anesthesia- Surface anesthesia is produce by direct application of anesthetizing agents on skin or membrane.
____	☒ **Conscious Sedation by RN** - Involves the use of intravenous medication administered by licensed registered nurses under the direct supervision of the physician performing the surgery/procedure.

DNR ORDERS: I understand that DNR (do not resuscitate) orders will be suspended while I am in the procedure and until I completely recover from the effects of anesthesia.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to the acceptance of anesthesia might be no anesthesia for the procedure.

☒ Joyce Sekera — 11/30/17 — 1034
Patient's Signature or Patient's Legal Representative — Date — Time

Signature of person witnessing the patient's or patient's legal representative signature — 11/30/17 — 1134
Date — Time

Valley View Surgery Center

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

JS500

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Next of Kin/*Pariente Próximo*:

Name/*Nombre*: Carole DiVito Relationship/*Relacion*: Mother

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702 610-6140

In Case of Emergency, I authorize VVSC to Contact/

En caso de Emergencia, yo autorizo a VVSC contactar a:

Name/*Nombre*: Marissa Freeman Relationship/*Relacion*: daughter

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702 525-9081

I authorize VVSC staff to discuss my medical care with / *Yo autorizo al personal de VVSC para discutir mi cuidado medico con:*

Name of person(s) / *Nombre de persona (s)* Marissa Freeman

Advance Directive / *Directivas Anticipadas*: (not applicable for patients under 18 years of age / *no es aplicable a pacientes menores de 18 años*)

Information regarding Advanced Directives is included in the Patient Information Packet /
La informacion sobre Directivas Anticipadas esta incluida en su paquete de informacion

____ **I do** have an advanced directive / ***Si tengo** una Directiva Anticipada;*

- A copy is provided to VVSC: **Yes** **No** / *Se propociona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive /
  Yo entiendo que es mi responsabilidad informar a mis medicos de mi Directiva Anticipada.

____ **I do not** have an advanced directive / ***Yo no** tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet/*Reconocimiento de paquete de informacion de paciente*:

As required by CMS (federal regulation), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (regulacion federal), por escrito y la notificacion n verbal sobre los Derechos y Responsabilidades de los Pacientes, directivas anticipadas y la politica correspondiente de la instalacion, y una lista de los dueños del negocio de VVSC se da a los pacientes. La firma debajo confirma que la a recibio por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☐ Received with previous date of service / *Recibido con la fecha anterior del servicio*

Signature: Joyce Sekera Date / *Fecha*: 11-30-17

Patient Representative signature (if other than patient; relationship:_____)

JS501

Valley View Surgery Center

Patient Acknowledgements

Patient label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

☐ Your insurance has been verified for the procedures scheduled by your doctor.

- Confirm name insurance company/companies
- Notice of OON ☒ N/A ☐ **Primary Ins.** ☐ **Secondary Ins.**
- According to the information from your insurance company, the *estimate* of your financial responsibility for the *scheduled procedure(s)* is:

☒ Co-pay ____ (not an estimate)

☐ Deductible [redacted]

☐ *Estimate* of Co-insurance ____

Total Due on DOS: $ 0-LIEN

☐ **ABN Needed** **Total Amount:** $____

☐ Did your doctor order any pre-op tests? If so, done? ☐ **Yes (where?)** ☐ **No** ☐ **N/A**

☐ **Verify Patient Demographics and insurance information**

☐ Patient Information Packet received at doctor's office?
If so, complete forms. If not, forms can be completed when arrive, bring list of meds.

☐ Confirm that patient is to follow the instructions received for doctor's office:

- Arrival time
- Nothing to eat or drink for time prior to admit

☐ Confirm knowledge of location of VVSC

☐ Bring with you:

- Photo ID and insurance cards
- List of current medications, prescription and over the counter, including vitamins for the past 6 months – Including dosage and last time taken.
- Payment as previously discussed
- A responsible adult to accompany you home.
- If you have an Advance Directive – bring a copy
- Leave jewelry, valuable at home.

Comments: NO PT RSP - ATTY LIEN - KEITH GALLIHER, ESQ

☐ Spoke with Patient ☐ left message ☐ no answer

Chart Prepped by: FH

☐ Per AdvantX Comment, pt pre-registered, 2nd call not made due to $0.00 due

Date and time called: 11/29/17 by: [illegible]

JS502

Valley View Surgery Center

Pre Operative Patient Call

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

\\VVSC-SVR01\LocalFolderRedirect\sbanks\Desktop\2017 INSURANCE RATES\Pre op Patient Call 2017.doc

Calculation of allowable charges and estimate of patient balance due on DOS

*First CPT code is the highest allowable + Second and all subsequent codes are 50% of Allowable
[Exception *CIGNA* contract = 100%, 50% for second code and 25% for third and subsequent codes]
[Exception *MDCD* contract = 100%, 50% for 2nd code, 25% 3rd code 10% for 4th and 5% subsequent codes]
[Exception *UHC* contract = 100%, 50% for 2nd code, 25% 3rd No additional codes will be reimbursed]

CPT Code	Allowable	(Sierra) x 90%	+ 50% for second procedure	Total Allowable
* L4135 x2	$2800.00			$2800
Total Allowable for scheduled procedures:				$2800
Enter amount of deductible not satisfied:				
If Total Allowable is less than Deductible not satisfied, The Total Allowable is the total to collect on DOS				
If Deductible not satisfied is less than Total Allowable, subtract deductible from allowable and enter balance here:				
If there is an implant that is not included in the allowable, enter amount of implant:				
Add the above 2 boxes, Total:				
Multiply the Total above by _____ % of co-insurance:				

JS503

Patient Valuables and Belongings List

Jewelry	How Many?	With Family	With Patient	In Safe	Comments
Watch	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Ring (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Necklace (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Bracelet	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Earrings/Piercings	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Valuables					
Unopened Purse/wallet	[ ]	[ ]	[ ]	[ ]	
Keys	[ ]	[ ]	[ ]	[ ]	
Cell Phone	[ ]	[ ]	[ ]	[ ]	
ID Card	[ ]	[ ]	[ ]	[ ]	
Ins. Card	[ ]	[ ]	[ ]	[ ]	
Credit Card	[ ]	[ ]	[ ]	[ ]	
Check Book	[ ]	[ ]	[ ]	[ ]	
Money/Currency	[ ]	[ ]	[ ]	[ ]	Amount $_____ [ ] Placed in enclosed envelope/secured VVSC safe.
Clothing					
Blouse/ Shirt	[ ]	[ ]	[ ]	[ ]	
Pants/Shorts	[ ]	[ ]	[ ]	[ ]	
Coat/Sweater Jacket	[ ]	[ ]	[ ]	[ ]	
Dress/Skirt	[ ]	[ ]	[ ]	[ ]	
Shoes/Slippers/Socks	[ ]	[ ]	[ ]	[ ]	
Hat/Belt/Vest	[ ]	[ ]	[ ]	[ ]	
Bra/slip/ Undergarments	[ ]	[ ]	[ ]	[ ]	
Equipment					
Cane/Walker/ Crutches	[ ]	[ ]	[ ]	[ ]	
Wheelchair/ Scooter	[ ]	[ ]	[ ]	[ ]	
Other	[ ]	[ ]	[ ]	[ ]	
*Eyeglasses/ Sunglasses	[ ]	[ ]	[ ]	[ ]	*In labeled Ziplock bag
Dentures/partials	[ ]	[ ]			

Patient Agreement at the time of Admission and Discharge

I understand that Valley View Surgery Center is NOT responsible for my personal belongings. I understand that I have been advised to leave my jewelry/valuables at home or with my responsible adult At VVSC.

PreOp

Patient/Representative (if patient is unable to sign): _____

RN Witness: _____ **Date:** 11/30/17

PACU/Discharge

Patient/Representative (if patient is unable to sign): _____

Patient/Representative attest that I went home with all belongings as listed above

[ ] RN [ ] CNA Witness: _____ Date: 11/30/17

JS504

Valley View Surgery Center

Patient Valuable and Belongings

M:\FORMS\Patient Valuable and Belongings Forms.docx rev 08/29/16vm

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

The injection you received contained an anesthetic or an anti-inflammatory steroid medication or both. You could possibly experience a decrease in your pain, numbness and/or weakness due to the anesthetic. The numbness and/or weakness usually lasts 2-8 hours and can at times last longer (should not be longer than 24 hours). Upon the anesthetic wearing off, you may experience some pain at the injection site and/or a temporary increase in your everyday pain. The increase of pain should decrease as the anti-inflammatory medication starts to take effect. This usually takes 3 to 5 days or possibly longer. Ice packs can be used to treat pain and/or inflammation at the injection site although ice packs should NOT be used for more than 20 minutes at a time.

Please refer to your doctor's instructions for ALL PROCEDURES to include limitations of activities, changes with your medications and his/her specific requirements.

[ ] Call your physician's office to schedule a follow up appointment.

[ ] If you are diabetic and received a steroid injection, check your blood sugar twice daily for one week and call your internal medicine physician if your blood sugar is 250 or greater.

[ ] Call your physician's office/answering service if you have any of the following symptoms...

- > Severe headache and/or seizures.
- > Loss of ability to feel or move your arms or legs
- > Infection (redness, swelling, drainage or fever greater than 101.5 F)
- > Heavy pressure over the chest or palpitations (rapid heartbeat)
- > Bleeding at the injection site that is not stopped within 15 minutes of direct pressure.
- > Difficulty breathing and/or speaking.
- > Adverse reaction to the medication given
- > Chills and/or sweating
- > Difficulty speaking and/or confusion

[ ] As ordered by your physician: You are to resume _____ in _____ days. [ ] N/A
Anticoagulant medication

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, CALL 911 OR GO TO THE NEAREST EMERENCY ROOM.

Dr. Travnicek
702-878-8252

Due to the injection procedure as well as the sedation you received during the procedure, DO NOT operate machinery, drive a vehicle, use stairs, drink alcoholic beverages, engage in any strenuous activities until the numbness has completely worn off and your full strength has returned. Do not sign legal documents for at least 24 hours if you were sedated for the procedure.

SPECIFIC INSTRUCTIONS AND/OR EXPECTATIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

[ ] EPIDURAL INJECTION/ SELECTIVE NERVE ROOT BLOCK **[ ] INTRATHECAL INJECTION**
[ ] LUMBAR SYMPATHETIC BLOCK **[ ] FACET JOINT INJECTIONS** **[ ] DISCOGRAM**
[ ] SACRO-ILLIAC JOINT INJECTION **[ ] KYPHO/VERTEBRALPLASTY** **[ ] ALL OTHER PROCEDURES**

As mentioned above, you may experience weakness in the back, arms and/or legs depending on the injection as well as an increase in pain after the anesthetic wears off. You should relax for the remainder of the day.

[ ] MEDIAL BRANCH BLOCKS
This is a diagnostic procedure using an anesthetic. A steroid might also be used depending on your doctor's preference. You should return to normal activity, which usually causes your neck or back pain to see if the procedure effectively reduces or eliminates your pain. This will be temporary lasting only for hours. You should keep a diary/journal and record how much your pain has been reduced and for how long. Bring this diary/journal with you to your follow-up appointment.

[ ] STELLATE GANGLION BLOCK
It is normal for your eyelid to droop, facial droop, hoarseness, numbness and/or weakness in your arm or face on the side of the injection. These symptoms should subside in 4 to 8 hours. If you develop any "stroke like" symptoms, such as slurred speech, unable to speak, confusion or unable to move your arms or legs, call 911 immediately or go to the nearest emergency room.

[ ] TRIGGER POINT INJECTIONS **[ ] INTERCOSTAL/PERIPHERAL NERVE BLOCK**
If any shortness of breath occurs, please call your physician. In cases of moderate to severe difficulty breathing call 911 or go to the nearest emergency room.

[ ] RADIOFREQUENCY / RF / NERVE ABLATION DENERVATION
You may experience more pain or discomfort after the procedure when the anesthetic wears off. This increase of pain can last 1 to 2 weeks and should gradually reduce while the radiofrequency procedure takes effect.

[ ] TRIAL OR PERMANENT SPINAL CORD STIMULATOR **[ ] SPINAL (INTRATHECAL) PAIN PUMP**
Both your physician and the equipment company representative will provide you with information relative to the equipment and the procedure. Please follow the instructions provided by your physician and the representative.

[ ] Copy given to patient: **DATE:** 11/30/17 **TIME:** 11:34 AM / PM

Patient's Signature _____ **Witness Signature** _____

Discharged to: James **Relationship:** neighbor

JS505

M:\pain\PAIN DISCH INSTRUCT 2016update.docx

Valley View Surgery Center
Discharge Instructions – Pain Management

Patient L
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 11/30/17 SEX: F

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: Joyce P Sekera
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: May 8, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED DIAGNOSTIC FACET JOINT MEDIAL BRANCH BLOCKS BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a styletted spinal needle was inserted percutaneously and directed to the lateral base of the superior articulating process at corresponding to each nerve to be anesthetized. Each site was then injected with contrast to confirm location and to rule out intravascular injection. Each site was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Afentanil Midazolam
CONTRAST: Omnipaque
INJECTATE (each site): Lidocaine (pf) 2% final concentration 0.5 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 5/08/2017 Time: 13:38:07

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS506

VALLEY VIEW SURGERY CENTER (VVSC) PATIENT REGISTRATION

Patient Information:

Name	Birthdate	Age	Sex	ACCT#
JOYCE P SEKERA	03/22/56	61	F	153654
Address	Race	Social Sec #	Marital Status	
7840 NESTING PINE PL	Unknown	091488430	S	
Las Vegas, NV 89143				
Home Phone: (702)467-5457	Cell Phone:			
Employer: brand vegas	Work Phone:			

Guarantor: SEKERA, JOYCE P — Patient's Relationship: Self
Address: 7840 NESTING PINE Las Veg NV 89143 — Phone: (702)467-5457

Primary Insurance:

Carrier: LIEN PAYER — Insured: SEKERA, JOYCE
Claims: ATTY; KEITH GALLIHER — Patient's Relationship: Self — Sex: F
Address — DOB: 03/22/1956 — SS#: 091-48-8430
1650 E. SAHARA #107 — Insurance ID: 00000000000 — Group #:
Las Vegas, NV 89104 — Auth #: APPROVED
Ins. Phone: (702)735-0049 — Employer: N/A

Secondary Insurance

Carrier: — Insured: ,
Claims: — Patient's Relationship: — Sex:
Address — DOB: — SS#:
Insurance ID: — Group #:
, — Auth #:
Ins. Phone: — Employer:

Date of Surgery: 05/08/2017 **Surgeon: TRAVNICEK, KATHERINE, M.D.**

Procedure: **BILAT 5-S1 INJECTION(S), DIAGNOSTIC** Type of Service: **Pain Management LUMB**
PreOp DX: M54.5

Authorization for treatment: I hereby authorize treatment at Valley View Surgery Center
I hereby authorized and permit VVSC to release medical billing data relating to this service
Financial agreement and assignment of payment/benefits: I understand that I am financially responsible for all charges incurred regardless of insurance coverage. I hereby verify that the insurance information that I have provided is correct and that VVSC will bill my insurance for services received. I hereby assign payment of all surgical and/or medical benefits payable on my behalf to VVSC for services at VVSC, not to exceed charges. Any unpaid deductible and/or estimated co-pay is due and payable on the day of service. The account is expected to be paid in full within 90 days from the date of service.
In the event my account is referred to a collection service due to lack of payment on my part, I acknowledge that there may be additional collection/legal fees added to my account.

Returned check charge: I understand that if a payment by check is returned unpaid by my bank for non sufficient funds (NSF), there will be a NSF fee charged to my account not to exceed $50.00. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

Acknowledgement of receipt of HIPAA privacy notice information and Patient Rights & Responsiblities.

Received this date, Initial: JS Received previously, Initial: _____

Signed: Joyce Sekera **Date:** 5/8/17

Relationship if other than patient: _____

Witnessed by: FH

JS507

SCHEDULED PROCEDURE: Bilateral Ls-S1 mBB

CHIEF COMPLAINT/ REASON FOR PROCEDURE:

- ☐ Head pain
- ☐ Neck pain
- ☐ Upper extremity pain
- ☐ Mid back pain
- ☑ Low back pain
- ☐ Sacral pain
- ☐ Lower extremity pain
- ☐ Other: _____

MEDICAL HISTORY: ☐ Other _____

See Pre-Anesthesia Record

Current medications – see Patient Home Medication List (Medication Reconciliation List)

HISTORY OF PREVIOUS PAIN MANAGEMENT PROCEDUDRE:

- ☐ No
- ☑ Yes

Justification for repeat Epidural Steroid Injection

- ☐ Partial Improvement
- ☐ Transient Improvement
- ☐ Significant Improvement
- ☐ Return of symptoms
- ☐ Persistent symptoms
- ☐ Other _____

SOCIAL/ FAMILY HISTORY:

- ☑ Non Contributory
- ☐ Other _____

ALLERGIES or ABNORMAL DRUG REACTIONS: ☑ NKA ☐ _____

PHYSICAL EXAM:

Heart/Cardiac RR

Lungs/Respiratory CTAB

Other _____

PLANNED ANESTHESIA:

- ☐ Anesthesiologist
- ☑ VCS-RN ASA Score: ☐ 1 ☑ 2 ☐ 3 ☐ 4

PRE-OPERATIVE DIAGNOSIS:

☑ Spondylosis (facet pain)	☐ Cervical	☐ Thoracic	☑ Lumbar
☐ Spondylosis w/o myelopathy	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Displacement of intervertebral disc	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Degeneration Disc Disease	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Post Laminectomy Syndrome	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Other _____			

ABNORMAL FINDINGS TO BE ADDRESSED ON DATE OF SERVICE PRIOR TO PROCEDURE: ☐ NA

_____

_____ MD'S Signature ☐ Proceed ☐ Cancel procedure

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia. The Patient is cleared for procedure in VVSC.

DISCHARGE NOTE:

Complications ☑ None

☐ Other: _____

Condition Stable: ☑ Discharge to home

JS508

Physician signature: _____

Valley View Surgery Center

Pain Management History & Physical

Patient N

Patient NAME: SEKERA, JOYCE P
ACCT: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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Date	NORD R. Gerdd 050817 0940 STANDING ORDERS
Nurse Notation:	
	PRE-OP ORDERS: Admit to Valley View Surgery Center for scheduled procedure on consent.
	1. Urine pregnancy test on females having periodic menstrual cycles unless post hysterectomy or no menstrual period for more than a year. Results of Pre-Op blood or urine tests completed 7 days or less prior to procedure will be accepted for pregnancy screening.
	2. Obtain BP, Blood Sugar and HCG results (if applicable) on patients prior to having the patient change for the procedure.
	3. Do blood glucose level on all diabetic patients. Report results greater than 150.
	4. Insert 20G IV cath for Saline lock or IV solution. Flush w/ 3 mls 0.9% NS PRN. May use 0.5% Lidocaine 0.1-0.2mls subcutaneous before insertion. Start IV 0.9 NS 250 mls KVO on non-operative side for cervical procedures.
	5. -Discograms: Ancef 1900mg IVP/IVPB (Ancef 2900mgs IVPB for patients 120kg or greater) -Hardware Blocks, Implants, Plexus Block, Pump Refills, Superior Hypogastric Block, †TSCS and patients with history of MVP, and Subacute Bacterial Endocarditis: Clindamycin 900mg IV.
	7. For cervical transforaminal injections, give Ondansetron (Zofran) 4mg IVP over two to 5 minutes.
	8. For Stellate Ganglion and Sympathetic injections, record a baseline temperature on appropriate bilateral extremities.
	9. Document the date patient discontinued any of the following medications. Acceptable days of discontinuance from date of procedure: [ ]ASA-7days, [ ]Coumadin or [ ]Plavix- for7 days. [ ] Except for Celebrex, all non-steroidal anti-inflammatory medications for 4 days. Inform MD if days do not meet criteria.
	10. For blood patch procedures: Using sterile technique, insert at minimum a 20G IV catheter (preferable 18G) in the antecubital vein as the second IV site for blood draw
	Surgical Consent to read (CHECK ALL THAT APPLY):

CERVICAL ———— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection) ***
[ ] Stellate Ganglion [ ] Radiofrequency [ ] Discography [ ] Greater/Lesser Occipital
LEVELS: [ ]C2 [ ]C3 [ ]C4 [ ]C5 [ ]C6 [ ]C7 [ ]C8 [ ]C1-2 [ ]C2-3 [ ]C3-4 [ ]C4-5 [ ]C5-6 [ ]C6-7 [ ]C7-T1

THORACIC ———— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)*** [ ] Radiofrequency [ ] Discography
LEVELS: [ ]T6 [ ]T7 [ ]T8 [ ]T9 [ ]T10 [ ]T11 [ ]T12 [ ]T6-7 [ ]T7-8 [ ]T8-9 [ ]T9-10 [ ]T10-11 [ ]T11-12 [ ]T12-L1

LUMBAR ———— [ ] Left [ ] Right [X] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [X] MBB (Facet Nerve Injection)***
[ ] Sympathetic [ ] Radiofrequency [ ] Discography [ ] Caudal/Catheter Directed [ ] Sacroiliac Joint
LEVELS: [ ]L1 [ ]L2 [ ]L3 [ ]L4 [ ]L5 [ ]S1 [ ]S2 [ ]L1-2 [ ]L2-3 [ ]L3-4 [ ]L4-5 [X]L5-S1
[ ] **OTHER:** [ ] †TSCS [ ] _____
[X] **UNDER FLUOROSCOPY** †TSCS Trial Spinal Cord Stimulator
*SNRB=Selective Nerve Root Block **TFESI=Transforaminal Epidural Steroid Injection ***MBB=Medial Branch Block

INTRAOPERATIVE ORERS: Oxygen at 2-4 L/NC **CONSCIOUS SEDATION** [X] Versed 1 mg [X] Alfentanil 500 mcg
[ ] Propofol _____ mgs [ ] Fentanyl _____ mcg [ ] Romazicon _____ mg
Versed 5/8/17 @ 1254 - PCP N
For Radiofrequency Treatment: See RF Neurotomy Procedural Notes Form. Medications drawn up as ordered on MD preference cards.

	PACU ORDERS
	1. Check vitals every 5 minutes x 2 then up to discharge with 1 set of vitals. Record post-procedure temperature readings on patients who received Stellate Ganglion and Sympathetic injection procedures. If local infiltrate and no sedation performed, take vital signs x1. Discharge when patient stable.
	2. For Stellate Ganglion and Sympathetic injections, record temperature on appropriate bilateral extremities.
	3. Oxygen nasal prongs or mask to as needed to maintain pre-op oxygenation level.
	4. Ice chips or liquids as tolerated. Ondansetron 4mg IVP/IM for nausea or vomiting prn.
	5. Do blood sugar testing if pt. received treatment for blood sugar level.
	6. Remove IV catheter just before discharge.
	7. Resume all prior medications. [ ] NA
	8. Resume all anticoagulants on next scheduled dose after the procedure. [ ] NA
	9. Provide and review written copy of post procedure instructions with patient & family members.
	10. Pt may be discharged in ½ hr if post-reversal agent. [ ] yes [ ] no
	11. Other orders:

Noted Dr. Travnicek 5/8/17 1207

PHYSICIAN'S SIGNATURE: _____

VALLEY VIEW SURGERY CENTER
Standing Orders - K. Travnicek, M.D.

JS509

Patient Label
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: Joyce P Sekera
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: May 8, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED DIAGNOSTIC FACET JOINT MEDIAL BRANCH BLOCKS BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a styletted spinal needle was inserted percutaneously and directed to the lateral base of the superior articulating process at corresponding to each nerve to be anesthetized. Each site was then injected with contrast to confirm location and to rule out intravascular injection. Each site was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Alfentanil Midazolam
CONTRAST: Omnipaque
INJECTATE (each site): Lidocaine (pf) 2% final concentration 0.5 ml injected into each site.
PROCEDURE NEEDLE: 22g Quincke

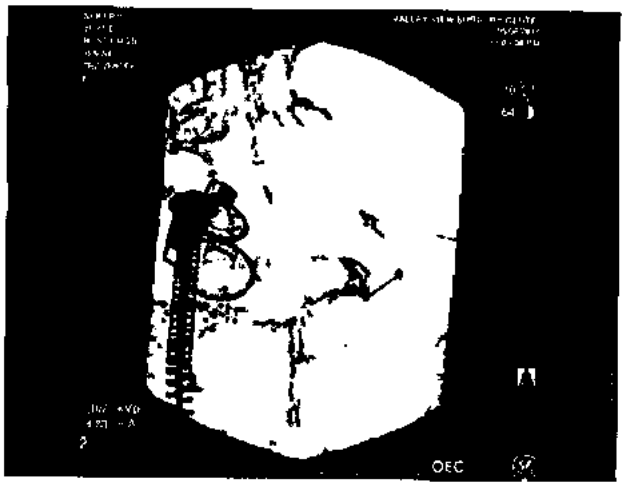
POST-PROCEDURE PAIN: 100% reduction in usual pain.

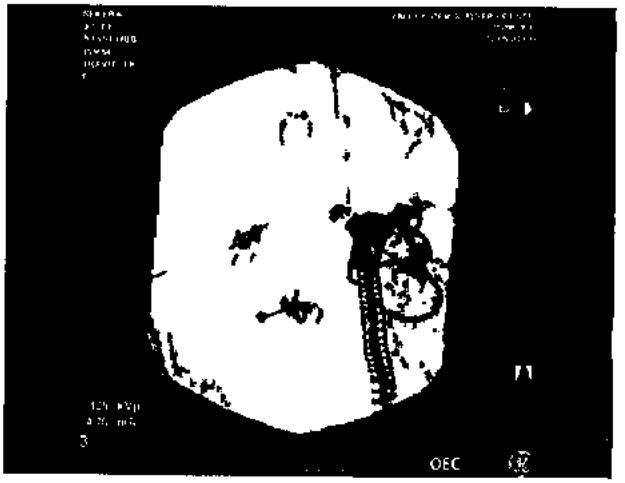
Electronically signed by KATHERINE TRAVNICEK Date: 5/08/2017 Time: 13:38:07

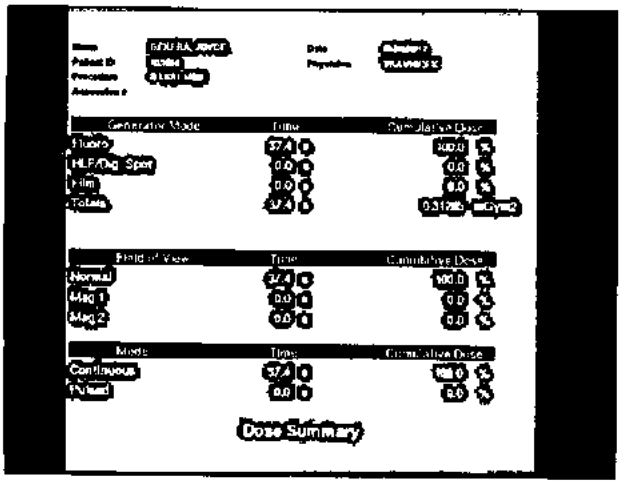
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

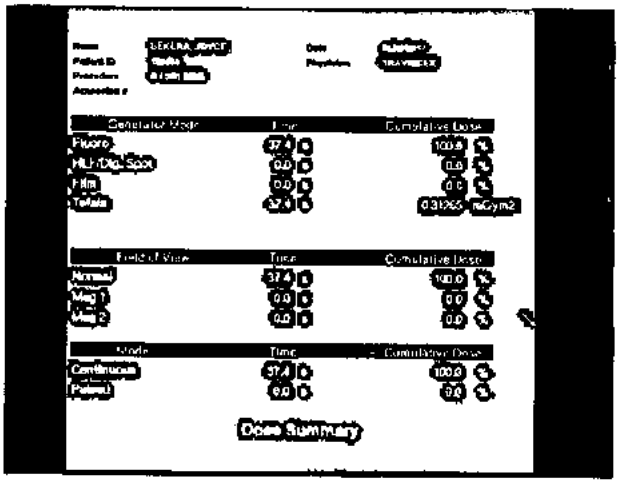
JS510

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F









NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Valley View Surgery Center

Fluoroscopic Images

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Patient label

JS511

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure.	Greet patient, check two patient identifiers and verify operative site, allergies and other pertinent information. Safety straps applied, patient positioned appropriately with good body alignment and pressure points padded.	Operative site, correct patient and permanent history verified. Allergies noted. Patient encouraged to ask questions about care in the operating room. Proper body alignment and safety straps used. Electrical equipment checked and ensured to be in safe condition.	Initials:

ALLERGIES: ☑ NKA ☐ See Front of Chart

TX # 1 Time in TX: 1250 "TIMEOUT" by M @ 1253 w/MD and all listed staff present

Time PROCEDURE BEGAN: 1255 Time PROCEDURE ENDED: 1301 TIME PT LEAVING TX 1305

If STAGED in room or change in position/different site area:

"TIMEOUT" by ____ @ ____ w/MD and all listed staff present

Time PROCEDURE BEGAN: ____ Time PROCEDURE ENDED: ____ TIME PT LEAVING TX ____

PAIN MANAGEMENT PERSONNEL:

DR. PERFORMING PROCEDURE: Dr. K. TRAVNICEK ANESTHESIA: ☑ IVCS ☐ MAC ☑ LOCAL INFILTRATE ☐ GENERAL ☐ OTHER

☐ ANESTHESIOLOGIST ☑ IVCS NURSE M. Cardenas RN CIRCULATOR A. Butler RN

MED NURSE B. Silverstein RN ☐ N/A SCRUB T. Swift CST X-RAY M. Pescatore OTHER ____

MEDICATIONS GIVEN BY PHYSICIAN DURING THE PROCEDURE:

☐ 1% Lidocaine MPF ☐ 0.5% Bupivacaine MPF ☐ 0.9% Normal Saline ☑ Omnipaque 300 mg plain

☑ 2% Lidocaine MPF ☐ Dexamethasone ☐ Myoblock ____ Units ☐ Omnipaque 300 mg Added ☐ Ancef ____ mg

☐ 4% Lidocaine MPF ☐ Methylprednisolone ☐ Pump medication verified with attending MD

(The dose and route of the medications given are noted on the procedural report of the physician performing the procedure.)

PRE-OP DIAGNOSIS: Lumbar Spondylosis

PROCEDURE: [ ] Cervical [ ] Thoracic [✓] Lumbar [ ] Caudal [ ] Hip [ ] Knee [ ] Shoulder (Number multiple procedures in sequence)

[ ] Discography

[ ] Epidural Steroid Injection

[ ] Facets: [ ] Right [ ] Left [ ] Bilateral

[ ] Intercostal Nerve Block: [ ] Right [ ] Left [ ] Bilateral

[✓] Medial Branch Block: [ ] Right [ ] Left [✓] Bilateral

[ ] Occipital, Greater/Lesser: [ ] Right [ ] Left [ ] Bilateral

[ ] Radiofrequency: [ ] Right [ ] Left [ ] Bilateral See RF Neurotomy Procedural Notes Form

[ ] Sacroiliac Joint: [ ] Right [ ] Left [ ] Bilateral

[ ] Selective Nerve Root Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Stellate Ganglion: [ ] Right [ ] Left [ ] Bilateral

[ ] Sympathetic Block, Lumbar [ ] Right [ ] Left

[ ] Transforaminal epidural steroid injection: [ ] Right [ ] Left [ ] Bilateral

[ ] Trial Spinal Cord Stimulator [ ] Trial Pain Pump [ ] Other ____

Prep to operative site: ☐ Duraprep ☑ Chloraprep: ☐ Tinted ☑ Clear By: T. Swift CST

Positioning: ☐ Supine ☑ Prone ☐ Lateral ☐ Arms tucked ☑ Pillows for positioning

☐ Padded toboggans used for arm protection ☑ Safety strap on x 3

POST OP DIAGNOSIS ☑ SAME ☐ Other ____ ☐ Pain log given

Notes: ____

☑ Radiation Skin Status - Pre Radiation ☑ All Clear Post Radiation ☑ All Clear

CIRCULATOR SIGNATURE A. Butler RN

Valley View Surgery Center

Pain Management OR Record

Dr. K. Travnicek

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Pre-OP-Vitals BP 144(?) HR 53 RR 18 O_2 Sat 96 % ☐ Room air ☐ Oxygen @ ___ L/min Temperature 96.7 F

ALLERGIES ☑ NKA

☐ See Front of Chart

Legend:
v = Systolic BP
^ = Diastolic BP
• = Pulse

Time	1250	1254	1255	1300
220				
210				
200				
190				
180	v			
170				
160				
150				
140				
130			v	v
120				
110				
100				
90				
80				
70	^		^	^
60				
50	•	•	•	
40				•
30				
SaO_2	100	100	99	100
RR	18	18	16	16
ETCO2	36	37	39	37
ETCO2 Waveform present ✓	✓	✓	✓	✓

O_2 Appliance: ☑ Cannula ☐ Mask
O_2 Liter Flow @ 3 L/min
ECG: ☐ NSR ☑ Sinus Bradycardia ☐ Sinus Tachycardia ☐ Other:
IV Site: ☑ Right arm ☐ Left arm ☐ Other:
Condition: ☑ Patent ☐ Other:
Solution: ☑ Saline Lock ☐ Isolyte ☐ 0.9% NaCl ☐ Other:
Acceptable range 35-45mmHg

CONSCIOUS SEDATION SCALE

	1250	1254	1255	1300
Respirations: 0. Appear Adequate 1. Impaired exchange 2. Dyspnea/Obstructed	0	0	0	0
Level of Consciousness: 0. Alert or awakening 1. Follows commands / Intermittent arousal 2. Unresponsive	0	0	1	1
Vital Signs: 1. Increase (+ 21% of pre-anesthetic level) 2. Within acceptable limits 3. Decrease (- 21% of pre-anesthetic level)	2	2	2	2
Physical/ Emotional Affect: 0. Resistive / Intense / Anxious / Uneasy 1. Tempered or Intermittent response/ Calm / Tolerant 2. No response	1	1	1	1
Total Sedation scale (Optimal 3-5)	3	3	4	4

MEDICATIONS D O S A G E S

Medication		
☑ Versed IV mg		1
☐ Fentanyl IV mcg		
☑ Alfentanil IV mcg		500
☐ Propofol IV mg		
☐ Romazicon IV mg		
☐ Narcan IV mg		
☐ Cefazolin IV mg		
☐ Other:		

IVCS RN Printed Name: M. Cardenas Signature: M. Cardenas, RN Initials [illegible]
Antibiotic: ☑ NA completed at ______ by ______
☑ Patient tolerated procedure well and was transferred to PACU in apparent good condition.
☑ Report given by IVCS/circulating nurse and care handed over to PACU Nurse D. Gasper RN

Patient Label

VALLEY VIEW SURGERY CENTER
IVCS by RN

JS513

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

M:\FORMS\Clinical forms\017A IVCS by RN.doc rev 100413 fd

Nursing Diagnosis	Outcome/Goal	Plan	Interventions/Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure	Ensure immediate , on-site availability of back-up personnel for airway management, resuscitative emergency intubation and emergency equipment	Emergency equipment will be present, working properly and immediately available in the room where the procedure(s) are performed Nursing assessment conducted by IVCS nurse including pertinent medical history, verification of allergies, confirmation of NPO status	
Potential decrease in blood pressure, heart rate, peripheral resistance and oxygen saturation, especially during administration of sedation agent(s)	Patient vital signs will remain within patient's normal limits as evident by the utilization of monitoring equipment peri-operatively	Explain monitoring equipment and ECG pads to patient	ECG electrodes, blood pressure cuff and pulse oximeter applied prior to procedure Vital signs will be monitored continually throughout the procedure at a minimum before the start of procedure, one minute after administration of medication(s) given, and at least every five minutes thereafter until procedure is completed	
Potential for anxiety and pain related to therapeutic and/or diagnostic procedures	Patient will be able to tolerate diagnostic and/or therapeutic procedures with reduced anxiety and discomfort. Patient's LOC will be mildly depressed with an altered perception to pain, but will retain the ability to respond appropriately to verbal and/or tactile stimulation	Sedation agent(s) will be administered per physician's orders	Pts LOC will be assessed at regular intervals, verbal reassurance will be given to divert patient's attention and assist in reducing anxiety	Initials: MC

Date: 5/8/17 Monitors On ☑ Alarms Set ☑ Allergies: ________ ☑ NKA

Procedure: Bilateral L5-S1 MBB ☐ See Front of Chart

PreOp: B/P 144/17 Pulse 53 RR 18 SaO2 96 % ☑ RA ☐ @ ___ L/min Temp: 97.3 Pain Level: 4 Initials ___

ADMIT TIME	BP	PULSE	RESP	O2 SAT	NC/RA	TEMP	PAIN LEVEL
1307	147/69	48	15	99	NC	97.4	0
1312	116/74	55	15	99	NC	–	0
1317	144/74	57	15	96	RA	–	3-4

POST ANESTHESIA ASSESSMENT RECOVERY SCORE			ADM	DISCHARGE
Purposeful movement of all extremities =2 Moves two extremities =1 No movement of extremities =0		Activity	1	2
Breath deeply and cough freely =2 Limited and/or impaired breathing =1 Apnea =0		Resp	2	2
BP stable or improved over PreOp readings. Pt. asymptomatic = 2 Pt. outside of acceptable range based on PreOp readings. =1 Unstable Hypotension or Hypertension = 0		Circ	2	2
Alert, fully awake, responding appropriately =2 Responds to name and/or verbal stimuli =1 Unresponsive =0		LOC	1	2
Normal skin color/SpO2 > 92% on room air = 2 Pale, Supplemental O2 for SpO2 > 90% =1 SpO2 < 92% with O2 supplementation =0		Color	1	2
Totals:				
DISCHARGE CRITERIA SCORE 10 or pre anesthesia			7	10

TIME	MEDICATION/DOSE/ROUTE/SITE FOR IM OR SQ INJECTIONS	PAIN LEVEL	INITIALS

NURSES NOTES: (Must make comments for "outcome discharge answers")

1317 - Dr's assistance @ bedside had pt stand up / bend to assess pain! pt rate pain @ 3-4/10.
1325 - Dr's assistance had pt stand up again + bend to reassess pain, pt now states pain @ 0/10. pt tolerating fluid / crackers.
D. Pasparen RN.

☐ Pt. given pain log and understands instructions as noted by pt.'s verbalization. ☑ NA

☐ Time: ________ Pt. up in wheelchair. Medically discharged. Waiting for ride.

Signature D. Pasparen Initials DP

Signature ________ Initials ________

DISCHARGE

Pt. tolerated procedure without apparent injury: ☑ Yes ☐ No*

Safety maintained: ☐ Yes ☐ No*

LOC: ☐ Alert ☑ Oriented same as PreOp level ☐ Sedated*☐

☐ Nausea/Vomiting ☑ N/A ☐ Minimal/Not treated ☐ Treated

Intake: PO 120 mls IV 0 mls

Discharge Criteria Met: ☑ Yes ☐ No*

IV catheter removed / catheter intact ☑ Yes ☐ No*

S/S of complications due to IV: ☑ No ☐ Yes*

Copy of post op instructions given to pt./other: ☑ Yes ☐ No*

Prescription given: ☑ NA ☐ Yes If yes, instructed pt. to take medication as written on prescription ☐ Yes ☐ No

Instructed pt. to resume medications as instructed / ordered by MD. ☑ Yes ☐ No

Pt./other states understanding of all instructions ☑ Yes ☐ No*

Mobility unchanged from Pre Op level ☑ Yes ☐ No*

Discharged via w/c to responsible adult ☑ Yes ☐ No*

Discharge Pain Level: ~~3-4~~ 0 Discharge Time: 1338

VALLEY VIEW SURGERY CENTER

POST PROCEDURE RECORD

Patient Label

NAME: SEKERA, JOYCE P JS515
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

M:\FORMS\Clinical forms\018-Post Procedure Record rev120716pp.doc rev120716pp

POST-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Altered airway Function Post-anesthesia	• Observe & maintain or support airway as needed • O_2 on arrival / PRN • Monitor SaO_2 • Appropriate position	Patient airway with maximum respiratory compliance as evidenced by adequate O_2 exchange, tissue perfusion & visible hemodynamics. Clear airway without assist	Goal is obtained: ☑ Yes ☐ No Comments:
Altered hemodynamics potential for hypovolemia	• Monitor EDG for arrhythmia • Note/intervene for B/P +/- 50% of pre-op reading • Observe surgical site for bleeding	Stable hemodynamics	Goal is obtained: ☑ Yes ☐ No Comments:
Altered level of consciousness	• Stimulate adult patient PRN • Do not stimulate pediatric patient if airway & hemodynamics are stable • Orient patient to surroundings • Observe for altered L.O.C.	Patient will be arousable, oriented and as alert as possible prior to discharge	Goal is obtained: ☑ Yes ☐ No Comments:
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety. Able to verbalize pos-op instructions (i.e. diet, wound care, pain control & activity)	Goal is obtained: ☑ Yes ☐ No Comments:
Potential injury	• Utilize side rails (pads PRN) • Place bed in low position • Secure IV's and assess for patency • Ensure correct physiological positioning	No injury in PACU	Goal is obtained: ☑ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Relief of pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments:
Nausea & Vomiting ☑ N/A	• Recognize nausea • Medicate as ordered • Teach relaxation techniques • Position for comfort & to prevent aspiration	Relief of nausea verbalized	Goal is obtained: ☐ Yes ☐ No Comments:

Initials of Nurse RN

Nurses Notes Continued as needed:

If EKG strip affixed to record, complete the following:

Time _____ am/pm

Dr. _____ notified @ _____ am/pm

Per MD's order: ☐ No treatment
☐ Treatment: _____

Signature of RN: _____ Time: _____ am/pm

JS516

Debbie

Date: 050817 Time Admitted: 1115 **PRE-OP CHECKLIST** 702 610-6170

Pt. Identified by ☑ full name ☑ date of birth by ______ From: ☐ Home ☐ Other ______ Via: ☑ Walking ☐ Wheelchair ☐ Carried

Planned Procedure: Bilateral L5-S1 MBB NPO since: 050817 AM Meds: ☐ Yes ☑ No

Responsible Adult taking pt. home: Mother Driver: Carole ☐ Same ☐ Waiting ☑ Call at:

MEDICAL HISTORY: ☐ Asthma ☐ Ulcers ☐ Hiatal Hernia ☐ TMJ ☐ SOB ☑ Diabetes ☐ MVP ☐ Stroke ☐ Sleep Apnea ☐ Hepatitis ☐ Hypertension ☑ Smoker ☑ Chest Pain/Previous MI (Date ______) ☐ Palpitations ☐ Seizures ☑ Back/Neck Problems ☐ Thyroid Problems ☐ AIDS/HIV Positive ☐ Street Drugs ☑ Arthritis ☑ Osteoporosis ☐ Other/Notes:

SURGICAL HISTORY: ☐ Tonsils/Adenoids ☐ Gallbladder ☐ Hysterectomy ☐ CABG ☐ Hernia ☐ Appendix ☐ Back ☑ Hip ☐ Sinus/Nasal ☐ Biopsy ______ ☐ D&C ☑ Laparoscopy ☐ Metal Implants ☐ Pacemaker/ICD ☐ Foot ☐ Cervical ☐ Knee ☐ Eye Surgery ☐ Other/Notes:

Medication list: See Pre-Anesthesia Record and Patient Home Medication List

VITAL SIGNS: Weight 135 kg Height 5'10"
SAO2 94 % ☑ RA @ ____ L/min Temp 96.7 Pulse 73 Resp 18
BP 144/77 ☑ R ☐ L arm Extremity temp: R ____ L ____ ☑ NA

ALLERGIES: ☑ NKA

☐ See Front of Chart

SYSTEMS ASSESSMENT ☑ or ☑ = Fall Risk (If ≥4 ☑ or ☑ checked, ☑ Fall Risk Band applied

Respiratory:
Respiration: ☑ unlabored ☐ labored ☐ other
Breath Sounds: ☑ audible ☑ clear ☐ other
Cough: ☑ absent ☐ non-productive ☐ productive ☐ other

Cardiovascular:
Heart tones: ☑ regular ☐ irregular ☐ other
Color: ☑ pink ☐ cyanotic ☐ other

Neuro Sensory:
☑ alert ☑ oriented ☑ confused ☐ other

Psychosocial: ☑ calm ☐ anxious ☐ crying ☐ angry ☐ other

Skin: ☑ normal ☐ pink ☐ cyanotic
☑ warm ☐ cool ☐ dry ☐ diaphoretic ☐ other

GI / GU: ☑ normal ☐ incontinent ☐ other

Activity: ☑ full ☐ ROM ☑ uses assistive device ☑ Fall within 3 mo ☐ other

*Pain Intensity Level: 4 Location: low back Pain Quality: constant

CHECKLIST	Yes	No	NA
Consent	✓		
H&P	✓		
H&P (Podiatry)			
CXR			
EKG			
CBC			
Coag.			
Urine			
Lytes/Chem panel			
Preg Urine/Serum			
Hepatitis Screen			
HIV			
Bowel prep finished			
Surgical Site Clipped			
Medical Clearance			
TEDs/SCDs			

PREMEDICATIONS:

Times	Medication / Dose	By

Pre-Op teaching done ☑ Yes ☐ No
Discharge inst. given ☑ Yes ☐ No
Patient side confirmed ☐ Yes ☐ No

Valuables w/	Patient	Family	None
Dentures	✓		
Glasses/Contacts			✓
Hearing aids			✓
Clothes		✓	
Jewelry/ Body Jewelry	*See back		✓

TESTING ON UNIT	RESULTS	N/A
Urine Pregnancy	1512 PMP (age)	
AccuChek		
☑ FBS ☐ RBS	88	
Normal range FBS 70 – 200 mg/dl		

Procedure or surgery site:
☑ Confirmed w/pt: ☐ right ☐ left ☑ bilateral ☐ NA
☐ Marked by MD

IV started in holding: ☑ Yes ☐ No Attempts X2 Initial (?)

Flush: ☑ 3 mls NS ☐ IV ______ ☐ ______ mls
Site: ☐ R ☐ L ☑ Superior Dorsal ☐ Anticubital vein
☐ Other: ______ Gauge ☐ 18 ☐ 20 ☑ 22 ☐ 24 Exp: 0/W
ID band applied by: ______
☐ Pt. tolerated tx. ☐ Other ______

SIGNATURES (Initial)
R. Genao (RG)
( )

To OR via: ☐ gurney ☐ side rails up ☐ bed ☐ low ☐ carried ☐ walk in

Valley View Surgery Center
PRE-OP CHECKLIST
M:\FORMS\Clinical forms\PRE OP CHECKLIST rev120716pp

Patient Label
NAME: SEKERA, JOYCE P JS517
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

PRE-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety	Goal is obtained: Yes No Comments:
Potential injury	• Utilize side rails (pads PRN) • Place bed in low position/chair locked • Secure IVs & assess for patency • Ensure correct physiological positioning	No injury in Pre-Op	Goal is obtained: Yes No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Pain verbalized using pain scale	Goal is obtained: Yes No Comments:

Pre-Op Nurse Initials: IB

NURSE'S NOTES

*Confirmed/witnessed with pt.: Jewelry secured in closed plastic bag. Bag placed in pt.'s belonging bag.

Nurse's Initials: _____

TIME	
1150	Patient was diagnosed of Diabetes 2 days ago. Does not take medication or exam it yet - IB

Reference: AAAHC Institute for Quality Improvement, *Patient Safety Toolkit: Ambulatory Surgery and Preventing Falls*, 07/22/13

JS518

Height / Estatura	5'6"	Actual Weight / Peso	225 lb.

Allergies / Alergias: nka

1. Have you taken any of the following medications:
Ha tomado los medicamentos listados:

Aspirin: Yes, date last taken / Aspirina: Si, ultima fecha tomada	_____	☑ No
Plavix: Yes, date last taken / Si, ultima fecha tomado	_____	☐ No
Coumadin: Yes, date last taken / Si, ultima fecha tomado	_____	☐ No
Anti-Inflammatory: Yes, date last taken / Anti-Inflamatorios Si, ultima fecha tomado	_____	☐ No

2. For female patients only:
Date of last menstrual period_____ ☐ N/A
Para mujeres solamente: fecha de su ultima menstruación_____

3. List all previous surgeries (and when)
Lista de todas cirugías previas (con fechas)

4. Do you symptoms of tuberculosis
Ha sido diagnosticado con Tuberculosis-

-Productive cough / -Tos productiva	☐ Yes ☑ No	-Weakness, Fatigue / -Fatiga, debilidad	☑ Yes ☐ No
-Bloody sputum / -Esputo con sangre	☐ Yes ☑ No	-Night sweats / -Sudores nocturnos	☐ Yes ☑ No
-Unexplained weight loss / -Perdida de peso inexplicable	☐ Yes ☑ No	-Fever / -Fiebre	☐ Yes ☑ No

HISTORY / HISTORIAL	Yes / Si	No
5. Have or are you taking "street drugs" **If yes, last date**_____ Ha o está tomando drogas ilegales En caso que si, fecha ultima: _____	☐	☑
6. Do you use Medical Marijuana? **If yes, last date:**_____ Utilizas la marihuana medicinal En caso que si, fecha ultima:_____	☐	☑
7. Have you had recent weight change? (Significant amount) Has tenido cambio significante en peso		

HISTORY / HISTORIAL	Yes / Si	No
8. Do you smoke? **If yes, cigarettes per day:** 4 ¿Fuma? En caso que si, cuantos cigarrillos per día ___	☑	☐
9. Do you have caps, false teeth, bridge, partials or contact lenses? ¿Tiene dientes falsos, tapas, dentaduras/Puente parsial o lentes de contacto	☑	☐
10. Do you drink alcoholic beverages? **If Yes, how much _____, last time_____** ¿Consume bebidas alcolicas? En caso que si, cantidad _____	☐	☑
11. Have you ever experienced any reaction to rubber or latex products? Alguna vez ha experimentado una reacción a los productos de goma o látex **If yes, please describe** En caso que si, por favor describa	☐	☑
12. Glaucoma Glaucoma	☐	☑
13. TMJ (dysfunction of temporomandibular joint) TMJ (disfunción de la articulación temporomadibular)	☐	☑
14. Stiff neck Cuello tieso	☐	☑
15. Shortness of breath Dificultad para respirar	☐	☑
16. Asthma Asma	☐	☑
17. Heart attack Ataque de Corazón	☐	☑
18. Chest pain; angina Dolor de pecho	☐	☑
19. Palpitations Palpitaciones	☐	☑
20. High blood pressure Alta presión	☐	☑
21. Implanted pacemaker/defibrillator Marcapasos / desfibrilador	☐	☑

CONTINUE ON BACK
CONTINUAR EN LA PARTE POSTERIOR

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17
AGE: 61
SEX: F

JS519

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)

M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

HISTORY HISTORIAL	Yes SI	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☒
23. **Hepatitis** Hepatitis **If Yes /** En caso que si **Type** ☐ A ☐ B ☐ C	☐	☒
24. **Hiatal Hernia** Hernia Hiatal	☐	☒
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** _____ ¿En caso afirmativo, cuando? _____	☒	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☒
27. **Ulcers** Ulceras	☐	☒
28. **Stroke** Derrame Cerebral	☐	☒
29. **Seizures** Convulsiones	☐	☒
30. **Parkinson disease** Enfermedad de Parkinsons	☐	☒
31. **Blackouts** Desmayos	☐	☒
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☒
33. **Back / Neck Problems** Problemas de cuello / espalda	☒	☐
34. **Osteoporosis** Osteoporosis	☐	☒
35. **Muscle Diseases** Enfermedad Muscular	☒	☐
36. **Arthritis** Artritis	☐	☒
37. **Diabetes** Diabetes	☒	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☒
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☒
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☒
41. **Blood Transfusion** Transfusión de sangre	☐	☒
42. **Kidney Disease** Enfermedad de Riñones	☐	☒
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que Si, fecha de ultimo tratamiento?	☐	☒

HISTORY HISTORIAL	Yes SI	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☒
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☒
46. **Metal Implants** Inplantes Metálicos	☐	☒
47. **Cancer** **If Yes, Where**_____ Cancer En caso que Si, en donde_____	☐	☒
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☒
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☒
50. **Draining wound** Herida abierta	☐	☒
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☒
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☒

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

_____

Signature (Patient/ or Person filling out form)
(If other than patient; relationship : _____)

_____

Firma (Paciente/representante)
(relación al paciente: _____)

5/8/17
Date/Fecha

_____ 05/8/17
Signature of Pre Op Nurse — Date

☐ = Fall risk

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

JS520

Valley View Surgery Center

PATIENT HOME MEDICATION LIST (As Provided by Patient)

Please fill in highlighted areas only and bring form back to VVSC before or on the day of your procedure.

☐ No Known Allergies

ALLERGIES AND THEIR REACTIONS:

List all medications taken over the past 6 months (Include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment.)

Medication Name	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: 3/9/17 Last Taken (Date/Time)	Date of Visit: 5/8/17 Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)
None							

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	☐**New Rx given to pt Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt Copy in MR

**Pre-Op Nurse Signature

* Complete Medication Information Unknown by pt. = CMI Unk

¥ is PACU Nurse Signature

** ☒Check box if pt./cg instructed on medication use, common side effect, and aftercare upon discharge.

**	**	**	**
*☐CMI Unk	*☐CMI Unk	*☐CMI Unk	*☐CMI Unk
☐ ¥	☐ ¥	☐ ¥	☐ ¥
☐Copy of med list given to pt. on DC.	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC

******** Contact your prescribing physician for questions regarding any medications listed on this page ********

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

PATIENT LABEL

PATIENT LABEL

VVSC Surgical/Procedural Safety Checklist

Note: Patient is patient himself/herself or legal representative or surrogate	Pre-Op	OR	PACU
1. Ensure a clean and sanitary environment for each patient.	✓	✓	✓
2. Patient identified as per VVSC policy & ID Band is on patient	✓	✓	✓
3. Allergies/ adverse reactions verified and stated on front of chart	✓	✓	✓
4. Surgery/Procedure Consent: Operative Procedure & site verified with patient	✓	✓	
a. Patient's Signature	✓	✓	
b. Witness Signature	✓	✓	
5. Anesthesia Consent:	✓	✓	
a. Patient's Signature	✓	✓	
b. Anesthesia Provider (Anesthesiologist or MD performing procedure) Signature	✓	✓	
6. H & P – to include heart and lung (Noted on Pre-Op checklist form)	✓	✓	
7. Pre-Op MD Orders	✓	✓	
a. As ordered, pre-op test(s): ☐ Completed, results reviewed and placed in chart ☐ Not present, action taken (See pre-op checklist nurse's note) ☑ N/A	✓	✓	
b. Standing Orders to draw blood sugar and /or urine pregnancy test ☑ N/A	✓	/	
c. Actions if blood sugar is out of range. Noted on back of Pre-Op Checklist and in blood sugar result log ☐ N/A	✓		
d. Antibiotic as ordered: ☐ Initiated ☐ Completed ☑ N/A	✓	✓	
e. *Any special equipment, devices, implants ☐ Yes ☑ N/A	✓	✓	
8. Procedure Site: MD marked Operative site ☐ Yes ☑ N/A	✓	/	
9. Pre-Op Anesthesia/Nurse Assessment Form / Medication List	✓		
a. Patient Signature	✓		
b. Nurse Signature	✓		
c. Medication list has dosage, frequency, date last taken. If pt. doesn't know, document	✓		
Any G-Code documented? ☐ No ☐ Yes List G-Code_____ See back of sheet for	✓		
10. IntraOp or Intra Treatment: Ensure a clean and sanitary environment for each patient	✓		
11. Intra Operative briefing before procedure started: *Time-Out* performed per policy, allergy status and other concerns discussed- *difficult airway or aspiration risk or aspiration risk, risk of blood loss if applicable			
12. *Procedure site is marked and visible ☐ N/A			
13. *Relevant images properly labeled and displayed ☐ N/A			
14. *De-briefing after completion of procedure			
a. Name of procedure performed			
b. Sponge, sharp count performed ☑ N/A			
c. Specimens identified and labeled ☑ N/A			
d. *Any equipment problems to be addressed ☑ N/A			
e. *Key concerns for recovery and management of this patient ☑ N/A			

JS522

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

	Pre-	OR	PACU
15. Sterilization Documentation completed/initialed			
16. O. R. Record Complete with out of OR time			
# 10 to #16 completed by			
Any G-Codes occurrences? ☑ No ☐ Yes List G-Code_____ **See below for references**			
17. Ensure a clean and sanitary environment for each patient			DK
18. Admit time to PACU			DK
19. Post Op Orders Noted			DK
20. Signature of Discharging MD for anesthesia recovery Discharge time on PACU record			DK
21. Discharge time to home or transfer to hospital noted ☑ Yes			DK
22. Copy of VVSC's prescriptions ☐ Yes ☑ N/A			DK
23. Name of responsible adult pt. discharged to noted on discharge instructions			DK
24. Phone number of the physician doing surgery or procedure on discharge instructions			DK
Any G-Codes occurrences? ☑ No ☐ Yes List G-Code_____ **See below for references**			DK

Nurse Name: **Printed** M Genova	Signature: Genova	/ Initials:
Nurse Name: **Printed**	Signature:	/ Initials:
Nurse Name: **Printed** D. Gregory	Signature: D. Gregory	/ Initials: DG
Nurse Name: **Printed**	Signature:	/ Initials:
Nurse Name: **Printed**	Signature:	/ Initials:
RN Co-sign for LPN: **Printed**	Signature:	/ Initials:

ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE First and last name initials signify the nurse has completed the listed responsibility. "O" with initials next to it signifies the nurse assessed the responsibility and completion is needed.*Revisions/Additions to this form adopted from AORN Comprehensive Surgical Checklist that incorporated WHO, Joint Commission-Universal Protocol (JC) 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	**G8908** Patient documented to have received a burn prior to discharge
Patient Fall	**G8910** Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	**G8912** Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	**G8914** Patient documented to have experienced hospital transfer/admission
Prophylactic IV Antibiotic Timing	**G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
	G8917 Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.

I consent to the admission to Valley View Surgery Center (VVSC) for my treatment(s) and authorize VVSC, staff, and doctor(s) to provide care. I authorize and direct **DR. TRAVNICEK** to perform the following treatment(s) or any other treatment deemed necessary at the discretion of the physician:

BILATERAL LUMBAR FIVE-SACRAL ONE MEDIAL BRANCH BLOCKS WITH THE USE OF FLUOROSCOPIC GUIDANCE

Physicians providing services at VVSC are not agents or employees of VVSC.

I understand I have the right to be informed. My physician has explained the treatment(s) necessary to treat my condition, purpose of the treatment and its associated anticipated benefits, including but not limited material risks, and alternative methods of treatment and its associated anticipated benefits, including but not limited material risks. No guarantee has been given as to the results that may be obtained. I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results. I have the right to be informed of the likelihood of success and the problem(s) associated with recuperation and the possible results of non-treatment. I have the right to request/consent to or to refuse any proposed treatment at any time prior to its performance.

I have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation/procedure. I have the right to be informed if any professional relationship to another health care provider or institution that may suggest a conflict of interest exists.

If applicable, I authorize the administration of anesthesia from an anesthesia provider as may be deemed necessary for the treatment.

My signature below authorizes the pathologist to use his/her discretion in disposing of any tissue removed from my person during the treatment(s) described above. I authorize x-rays, photographs, or videotaping for diagnostic or medical education purposes including utilization of medical residents, students, and/or manufacturing representatives.

I authorize to the drawing of a blood sample from my body in the event that an employee or physician of the surgery center has an accidental puncture or mucous membrane (eye, mouth, etc) exposure to my blood or body fluids. The blood samples will be tested for HIV and Hepatitis. No results of any tests done on my blood will be released or shown to any unauthorized person without my written consent.

My signature on this form indicates that I have read and understand the information provided on this form, that the treatment(s) described above has been adequately explained to me by my physician, that I have had the opportunity to ask questions, that I received the information I desire concerning the treatment, and that I consent and authorize to the performance of the treatment(s) upon myself.

I understand and agree that I am solely responsible for maintaining the privacy of my protected health information in the paperwork I received.

I have not eaten or drank since (Date& Time) 050817 4pm ☑ Fluid, _____ (am't), ☑ Solid 050817 7pm
I have a responsible adult to drive me home.

☒ Joyce Sekera — 050817 (Date) — 1130 (Time)
Patient's Signature or Patient's Representative or Surrogate
Relationship to Patient: ☑ Self ☐ Other

Kerri — 050817 (Date) — 1130 (Time)
Signature of person witnessing the patient's or patient's legal representative signature

☑ Verified consent — M Initials of circulator

< SEKERA, JOYCE >

JS524

Valley View Surgery Center

Treatment Consent/Authorization

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Ad NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Patient Consent for Anesthesia at Valley View Surgery Center

I understand:

I will need anesthesia services for the surgery/procedure to be done today.

- And the amount of anesthesia to be used will depend upon the procedure(s) and my physical condition. Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical/surgical procedure.
- During the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
- Although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are a part of the risks I must consider in deciding to have a procedure. Some of the unusual risks and complications of anesthesia may include but are not limited to allergic or adverse reactions, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and of redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/by others, seizures, sore throat, and death.
- A detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to inform me. No guarantees have been made by anyone regarding the anesthesia services which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS:

Patient Initials	
_____	☐ **General Anesthesia:** 1. Mask Anesthesia- Gases are passed through a mask which covers the nose and mouth or 2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth or 3. Laryngeal/Mask Anesthesia- Gases are passed through a mask placed behind the tongue which covers the larynx (voice box) or 4. Deep sedation.
_____	☐ **Regional Anesthesia** 1. Nerve block-Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.
_____	☐ **Monitored Anesthesia Care (MAC), Total Intravenous Anesthesia (TIVA)** - The anesthesiologist monitors blood pressure, oxygenation, pulse, and mental state and supplements sedation and analgesia as appropriate.
_____	☐ **Local Anesthesia** 1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedure site. 2. Topical Anesthesia- Surface anesthesia is produce by direct application of anesthetizing agents on skin or membrane.
JS	☑ **Conscious Sedation by RN** - Involves the use of intravenous medication administered by licensed registered nurses under the direct supervision of the physician performing the surgery/procedure.

DNR ORDERS: I understand that DNR (do not resuscitate) orders will be suspended while I am in the procedure and until I completely recover from the effects of anesthesia.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to the acceptance of anesthesia might be no anesthesia for the procedure.

X _____ 050817 1130

Patient's Signature or Patient's Legal Representative — Date — Time

_____ 050817 1130

Signature of person witnessing the patient's or patient's legal representative signature — Date — Time

Valley View Surgery Center

Anesthesia Consent

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Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS525

Next of Kin/*Pariente Próximo*

Name/*Nombre*: Carole DiVito Relationship/*Relacion*: Mother

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702-610-6140

In Case of Emergency, I authorize VVSC to Contact:

En caso de Emergencia, yo autorizo a VVSC contactar a:

Name/*Nombre*: Misty Freeman Relationship/*Relacion*: daughter

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702 525-9081

I authorize VVSC staff to discuss my medical care with / *Yo autorizo al personal de VVSC para discutir mi cuidado medico con:*

Name of person(s) / *Nombre de persona (s)* Carole DiVito/Marissa Freeman

---

Advanced Directive / *Directivas Anticipadas:* **(not applicable for patients under 18 years of age / *no es aplicable a pacientes menores de 18 años*)**

Information regarding Advanced Directives is included in the Patient Information Packet /
La informacion sobre Directivas Anticipadas esta incluida en su paquete de informacion

____ **I do** have an advanced directive / ***Si tengo*** *una Directiva Avancada;*

- A copy is provided to VVSC: **Yes** **No** / *Se propociona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive /
  Yo entiendo que es mi responsabilidad informar a mis medicos de mi Directiva Anticipada.

✓ **I do not** have an advanced directive / ***Yo no*** *tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet/*Reconocimiento de paquete de informacion de paciente*:

As required by CMS (federal regulation), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (regulacion federal), por escrito y la notificacion n verbal sobre los Derechos y Responsabilidades de los Pacientes, directivas anticipadas y la politica correspondiente de la instalacion, y una lista de los dueños del negocio de VVSC se da a los pacientes. La firma debajo confirma que la a recibio por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☑ Received with previous date of service / *Recibido con la fecha anterior del servicio*

X Joyce Sekera Date / *Fecha*: 5/8/17

Patient/Patient Representative signature (if other than patient; relationship: ____)

JS526

Valley View Surgery Center

Patient Acknowledgements

Patient label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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Patient Valuables and Belongings List

Jewelry	How Many?	With Family	With Patient	In Safe	Comments
Watch	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Ring (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Necklace (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Bracelet	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Earrings/Piercings	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Valuables					
Unopened Purse/wallet	[ ]	[ ]	[ ]	[ ]	
Keys	[ ]	[ ]	[ ]	[ ]	
Cell Phone	[ ]	[ ]	[ ]	[ ]	
ID Card	[ ]	[ ]	[ ]	[ ]	
Ins. Card	[ ]	[ ]	[ ]	[ ]	
Credit Card	[ ]	[ ]	[ ]	[ ]	
Check Book	[ ]	[ ]	[ ]	[ ]	
Money/Currency	[ ]	[ ]	[ ]	[ ]	Amount $_____ [ ] Placed in enclosed envelope/secured VVSC safe.
Clothing					
Blouse/ Shirt	[ ]	[ ]	[ ]	[ ]	
Pants/Shorts	[ ]	[ ]	[ ]	[ ]	
Coat/Sweater Jacket	[ ]	[ ]	[ ]	[ ]	
Dress/Skirt	[ ]	[ ]	[ ]	[ ]	
Shoes/Slippers/Socks	[ ]	[ ]	[ ]	[ ]	
Hat/Belt/Vest	[ ]	[ ]	[ ]	[ ]	
Bra/slip/ Undergarments	[ ]	[ ]	[ ]	[ ]	
Equipment					
Cane/Walker/ Crutches	[ ]	[ ]	[ ]	[ ]	
Wheelchair/ Scooter	[ ]	[ ]	[ ]	[ ]	
Other	[ ]	[ ]	[ ]	[ ]	
*Eyeglasses/ Sunglasses	[ ]	[ ]	[ ]	[ ]	*In labeled Ziplock bag
Dentures/partials	[ ]	[ ]			

Patient Agreement at the time of Admission and Discharge

I understand that Valley View Surgery Center is NOT responsible for my personal belongings. I understand that I have been advised to leave my jewelry/valuables at home or with my responsible adult At VVSC.

PreOp

Patient/Representative (if patient is unable to sign) : Joyce Sekera

RN Witness: [redacted] **Date:** [redacted]

PACU/Discharge

Patient/Representative (if patient is unable to sign) : Joyce Sekera

[redacted]

[ ] RN [ ] CNA Witness: [redacted] **Date:** [redacted]

Valley View Surgery Center

Patient Valuable and Belongings

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Patient Label

NAME: SEKERA, JOYCE P

ACT#: 153654

DOB: 03/22/56 AGE: 61

DR: TRAVNICEK, KATHERINE M.D.

DOS: 05/08/17 SEX: F

JS527

The injection you received contained an anesthetic or an anti-inflammatory steroid medication or both. You could possibly experience a decrease in your pain, numbness and/or weakness due to the anesthetic. The numbness and/or weakness usually lasts 2-8 hours and can at times last longer (should not be longer than 24 hours). Upon the anesthetic wearing off, you may experience some pain at the injection site and/or a temporary increase in your everyday pain. The increase of pain should decrease as the anti-inflammatory medication starts to take effect. This usually takes 3 to 5 days or possibly longer. Ice packs can be used to treat pain and/or inflammation at the injection site although ice packs should NOT be used for more than 20 minutes at a time.
Please refer to your doctor's instructions for ALL PROCEDURES to include limitations of activities, changes with your medications and his/her specific requirements.

[✓] Call your physician's office to schedule a follow up appointment.

[ ] If you are diabetic and received a steroid injection, check your blood sugar twice daily for one week and call your internal medicine physician if your blood sugar is 250 or greater.

[✓] Call your physician's office/answering service if you have any of the following symptoms...

- > Severe headache and/or seizures.
- > Loss of ability to feel or move your arms or legs
- > Infection (redness, swelling, drainage or fever greater than 101.5 F)
- > Heavy pressure over the chest or palpitations (rapid heartbeat)
- > Bleeding at the injection site that is not stopped within 15 minutes of direct pressure.
- > Difficulty breathing and/or speaking.
- > Adverse reaction to the medication given.
- > Chills and/or sweating
- > Difficulty speaking and/or confusion

[ ] As ordered by your physician: You are to resume _____ in _____ days. [✓] N/A
Anticoagulant medication

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, CALL 911 OR GO TO THE NEAREST EMERENCY ROOM.

Dr. Travnicek
702-878-8252

Due to the injection procedure as well as the sedation you received during the procedure, DO NOT operate machinery, drive a vehicle, use stairs, drink alcoholic beverages, engage in any strenuous activities until the numbness has completely worn off and your full strength has returned. Do not sign legal documents for at least 24 hours if you were sedated for the procedure.

SPECIFIC INSTRUCTIONS AND/OR EXPECTATIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

[ ] EPIDURAL INJECTION/ SELECTIVE NERVE ROOT BLOCK
[ ] LUMBAR SYMPATHETIC BLOCK
[ ] SACRO-ILLIAC JOINT INJECTION
[ ] FACET JOINT INJECTIONS
[ ] KYPHO/VERTEBRALPLASTY
[ ] INTRATHECAL INJECTION
[ ] DISCOGRAM
[ ] ALL OTHER PROCEDURES

As mentioned above, you may experience weakness in the back, arms and/or legs depending on the injection as well as an increase in pain after the anesthetic wears off. You should relax for the remainder of the day.

[✓] **MEDIAL BRANCH BLOCKS**
This is a diagnostic procedure using an anesthetic. A steroid might also be used depending on your doctor's preference. You should return to normal activity, which usually causes your neck or back pain to see if the procedure effectively reduces or eliminates your pain. This will be temporary lasting only for hours. You should keep a diary/journal and record how much your pain has been reduced and for how long. Bring this diary/journal with you to your follow-up appointment.

[ ] **STELLATE GANGLION BLOCK**
It is normal for your eyelid to droop, facial droop, hoarseness, numbness and/or weakness in your arm or face on the side of the injection. These symptoms should subside in 4 to 8 hours. If you develop any "stroke like" symptoms, such as slurred speech, unable to speak, confusion or unable to move your arms or legs, call 911 immediately or go to the nearest emergency room.

[ ] **TRIGGER POINT INJECTIONS** [ ] **INTERCOSTAL/PERIPHERAL NERVE BLOCK**
If any shortness of breath occurs, please call your physician. In cases of moderate to severe difficulty breathing call 911 or go to the nearest emergency room.

[ ] **RADIOFREQUENCY / RF / NERVE ABLATION DENERVATION**
You may experience more pain or discomfort after the procedure when the anesthetic wears off. This increase of pain can last 1 to 2 weeks and should gradually reduce while the radiofrequency procedure takes effect.

[ ] **TRIAL OR PERMANENT SPINAL CORD STIMULATOR** [ ] **SPINAL (INTRATHECAL) PAIN PUMP**
Both your physician and the equipment company representative will provide you with information relative to the equipment and the procedure. Please follow the instructions provided by your physician and the representative.

[✓] Copy given to patient: DATE: 05 / 08 / 17 TIME: 11:50 (AM) PM

Patient's Signature Joyce Sekera Witness Signature Renee

Discharged to: Carole Relationship: mother

M:\pain\PAIN DISCH INSTRUCT 2016update.docx

Valley View Surgery Center
Discharge Instructions – Pain Management

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS528

VALLEY VIEW SURGERY CENTER(VVSC) PATIENT REGISTRATION

Patient Information:

Name	Birthdate	Age	Sex	ACCT#
[redacted]	[redacted]	60	F	153654

Address
7840 NESTING PINE PL
Las Vegas, NV 89143
Home Phone: (702)467-5457
Employer: N/A

Race: Unknown
Social Sec #: [redacted]
Marital Status: [redacted]
Cell Phone:
Work Phone:

Guarantor: SEKERA, JOYCE P
Address: 7840 NESTING PINE Las Veg NV 89143
Patient's Relationship: Self
Phone: (702)467-5457

Primary Insurance:

Carrier: LIEN PAYER
Claims: ATTY; KEITH GALLIHER
Address
1850 E. SAHARA #107
Las Vegas, NV 89104
Ins. Phone: (702)735-0049

Insured: SEKERA, JOYCE
Patient's Relationship: Self Sex: F
DOB: 03/22/1956 SS#: 091-48-8430
Insurance ID: 00000000000 Group #:
Auth #: APPROVED
Employer: N/A

Secondary Insurance

Carrier:
Claims:
Address
,
Ins. Phone:

Insured: ,
Patient's Relationship: Sex:
DOB: SS#:
Insurance ID: Group #:
Auth #:
Employer:

Date of Surgery: 03/09/2017 **Surgeon: TRAVNICEK, KATHERINE, M.D.**

Procedure: **NO SEDATION** BI
PreOp DX: M54.5
Type of Service: Pain Management LUMB

Authorization for treatment: I hereby authorize treatment at Valley View Surgery Center
I hereby authorized and permit VVSC to release medical billing data relating to this service
Financial agreement and assignment of payment/benefits: I understand that I am financially responsible for all charges incurred regardless of insurance coverage. I hereby verify that the insurance information that I have provided is correct and that VVSC will bill my insurance for services received. I hereby assign payment of all surgical and/or medical benefits payable on my behalf to VVSC for services at VVSC, not to exceed charges. Any unpaid deductible and/or estimated co-pay is due and payable on the day of service. The account is expected to be paid in full within 90 days from the date of service.
In the event my account is referred to a collection service due to lack of payment on my part, I acknowledge that there may be additional collection/legal fees added to my account.

Returned check charge: I understand that if a payment by check is returned unpaid by my bank for non sufficient funds (NSF), there will be a NSF fee charged to my account not to exceed $50.00. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

Acknowledgement of receipt of HIPAA privacy notice information and Patient Rights & Responsibilities.

Received this date, Initial: [redacted] Received previously, Initial: _____

[redacted] Joyce Sekera 3/9/17

JS529

Relationship if other than patient: _____

Witnessed by: _____

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

SCHEDULED PROCEDURE: ~~Outpatient~~ ESI's. Bilateral Lumbar 5-Sacral, FU I

CHIEF COMPLAINT/ REASON FOR PROCEDURE:

- ☐ Head pain
- ☐ Neck pain
- ☐ Upper extremity pain
- ☐ Mid back pain
- ☑ Low back pain
- ☐ Sacral pain
- ☐ Lower extremity pain
- ☐ Other: _____

MEDICAL HISTORY: ☐ Other _____

See Pre-Anesthesia Record

Current medications – see Patient Home Medication List (Medication Reconciliation List)

HISTORY OF PREVIOUS PAIN MANAGEMENT PROCEDUDRE:

- ☑ No
- ☐ Yes

Justification for repeat Epidural Steroid Injection

- ☐ Partial Improvement
- ☐ Transient Improvement
- ☐ Significant Improvement
- ☐ Return of symptoms
- ☐ Persistent symptoms
- ☐ Other _____

SOCIAL/ FAMILY HISTORY:

- ☑ Non Contributory
- ☐ Other _____

ALLERGIES or ABNORMAL DRUG REACTIONS: ☑ NKA ☐ _____

PHYSICAL EXAM:

Heart/Cardiac _____

Lungs/Respiratory _____

Other _____

MGdodz

PLANNED ANESTHESIA:

- ☐ Anesthesiologist
- ☑ VVCS-RN **ASA Score:** ☑ 1 ☐ 2 ☐ 3 ☐ 4

PRE-OPERATIVE DIAGNOSIS:

☑ Spondylosis (facet pain)	☐ Cervical	☐ Thoracic	☑ Lumbar
☐ Spondylosis w/o myelopathy	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Displacement of intervertebral disc	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Degeneration Disc Disease	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Post Laminectomy Syndrome	☐ Cervical	☐ Thoracic	☐ Lumbar

☐ Other _____

ABNORMAL FINDINGS TO BE ADDRESSED ON DATE OF SERVICE PRIOR TO PROCEDURE: ☐ NA

_____

_____ MD'S Signature ☐ Proceed ☐ Cancel procedure

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia. The Patient is cleared for procedure in VVSC.

DISCHARGE NOTE:

Complications ☑ None

☐ Other: _____

Condition Stable: ☑ Discharge to home

Physician signature: _____

Valley View Surgery Center

Pain Management History & Physical

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

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JS530

Date / Nurse Notation:	STANDING ORDERS
	PRE-OP ORDERS: Admit to Valley View Surgery Center for scheduled procedure on consent.
	1. Urine pregnancy test on females having periodic menstrual cycles unless post hysterectomy or no menstrual period for more than a year. Results of Pre-Op blood or urine tests completed 7 days or less prior to procedure will be accepted for pregnancy screening.
	2. Obtain BP, Blood Sugar and HCG results (if applicable) on patients prior to having the patient change for the procedure.
	3. Do blood glucose level on all diabetic patients. Report results greater than 150.
	4. Insert 20G IV cath for Saline lock or IV solution. Flush w/ 3 mls 0.9% NS PRN. May use 0.5% Lidocaine 0.1-0.2mls subcutaneous before insertion. Start IV 0.9 NS 250 mls KVO on non-operative side for cervical procedures.
	5. -Discograms: Ancef 1900mg IVP/IVPB (Ancef 2900mgs IVPB for patients 120kg or greater) -Hardware Blocks, Implants, Plexus Block, Pump Refills, Superior Hypogastric Block, †TSCS and patients with history of MVP, and Subacute Bacterial Endocarditis: Clindamycin 900mg IV.
	7. For cervical transforaminal injections, give Ondansetron (Zofran) 4mg IVP over two to 5 minutes.
	8. For Stellate Ganglion and Sympathetic injections, record a baseline temperature on appropriate bilateral extremities.
	9. Document the date patient discontinued any of the following medications. Acceptable days of discontinuance from date of procedure: [ ]ASA–7days, [ ]Coumadin or [ ]Plavix- for7 days, [ ] Except for Celebrex, all non-steroidal anti-inflammatory medications for 4 days. Inform MD if days do not meet criteria.
	10. For blood patch procedures: Using sterile technique, insert at minimum a 20G IV catheter (preferable 18G) in the antecubital vein as the second IV site for blood draw
	Surgical Consent to read (CHECK ALL THAT APPLY):

CERVICAL ———— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection) ***
[ ] Stellate Ganglion [ ] Radiofrequency [ ] Discography [ ] Greater/Lesser Occipital
LEVELS: [ ]C2 [ ]C3 [ ]C4 [ ]C5 [ ]C6 [ ]C7 [ ]C8 [ ]C1-2 [ ]C2-3 [ ]C3-4 [ ]C4-5 [ ]C5-6 [ ]C6-7 [ ]C7-T1

THORACIC ———— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)*** [ ] Radiofrequency [ ] Discography
LEVELS: [ ]T6 [ ]T7 [ ]T8 [ ]T9 [ ]T10 [ ]T11 [ ]T12 [ ]T6-7 [ ]T7-8 [ ]T8-9 [ ]T9-10 [ ]T10-11 [ ]T11-12 [ ]T12-L1

LUMBAR ———— [ ] Left [ ] Right [X] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [X] Facet Joint Injection [ ] MBB (Facet Nerve Injection)***
[ ] Sympathetic [ ] Radiofrequency [ ] Discography [ ] Caudal/Catheter Directed [ ] Sacroiliac Joint
LEVELS: [ ]L1 [ ]L2 [ ]L3 [ ]L4 [ ]L5 [ ]S1 [ ]S2 [ ]L1-2 [ ]L2-3 [ ]L3-4 [ ]L4-5 [X]L5-S1
OTHER: [ ] †TSCS [ ] Bilateral
[ ] UNDER FLUOROSCOPY †TSCS Trial Spinal Cord Stimulator
*SNRB=Selective Nerve Root Block **TFESI=Transforaminal Epidural Steroid Injection ***MBB=Medial Branch Block

INTRAOPERATIVE ORERS: Oxygen at 2-4 L/NC **CONSCIOUS SEDATION** [ ] Versed _____mg [ ] Alfentanil _____mcg
[ ] Propofol _____mgs [ ] Fentanyl _____mcg [ ] Romazicon _____mg

For Radiofrequency Treatment: See RF Neurotomy Procedural Notes Form. Medications drawn up as ordered on MD preference cards.

	PACU ORDERS
	1. Check vitals every 5 minutes x 2 then up to chair/dangle with 1 set of vitals. Record post-procedure temperature readings on patients who received Stellate Ganglion and Sympathetic injection procedures. If local infiltrate and no sedation performed, take vital signs x1. Discharge when patient stable.
	2. For Stellate Ganglion and Sympathetic injections, record temperature on appropriate bilateral extremities.
	3. Oxygen nasal prongs or mask to as needed to maintain pre-op oxygenation level.
	4. Ice chips or liquids as tolerated. Ondansetron 4mg IVP/IM for nausea or vomiting prn.
	5. Do blood sugar testing if pt. received treatment for blood sugar level.
	6. Remove IV catheter just before discharge.
	7. Resume all prior medications. [ ] NA
	8. Resume all anticoagulants on next scheduled dose after the procedure. [ ] NA
	9. Provide and review written copy of post procedure instructions with patient & family members.
	10. Pt may be discharged in ½ hr if post-reversal agent. [ ] yes [ ] no
	11. Other orders:

PHYSICIAN'S SIGNATURE: _____

VALLEY VIEW SURGERY CENTER
Standing Orders - K. Travnicek, M.D.

JS531

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: March 9, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic and therapeutic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT INJECTION(S) BILATERAL L5-S1
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a stylette procedure needle was inserted percutaneously and directed to the posterior aspect of each facet joint to be injected without paraesthesia. Each site was then injected with contrast to confirm flow into the joint and to rule out intravascular or intrathecal injection. Each joint was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood and cerebrospinal fluid. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.
CONTRAST: Omnipaque
INJECTATE (each site): Dexamethasone 4 mg (pf) in Marcaine (pf) 0.5% final concentration. 1 ml injected into each site.
PROCEDURE NEEDLE: 22g Quincke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 3/09/2017 Time: 11:21:44

NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS532

Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure.	Greet patient, check two patient identifiers and verify operative site, allergies and other pertinent information. Safety straps applied, patient positioned appropriately with good body alignment and pressure points padded.	Operative site, correct patient and permanent history verified. Allergies noted. Patient encouraged to ask questions about care in the operating room. Proper body alignment and safety straps used. Electrical equipment checked and ensured to be in safe condition.	CM Initials:

ALLERGIES: ☒ NKA ☐ See Front of Chart

TX # 1 Time in TX: 1000 "TIMEOUT" by CM, KN @ 1005 w/MD and all listed staff present

Time PROCEDURE BEGAN: 1008 Time PROCEDURE ENDED: 1013 TIME PT LEAVING TX 1015

If STAGED in room or change in position/different site area:

"TIMEOUT" by _____ @ _____ w/MD and all listed staff present

Time PROCEDURE BEGAN: _____ Time PROCEDURE ENDED: _____ TIME PT LEAVING TX _____

NO SEDATION

PAIN MANAGEMENT PERSONNEL

DR. PERFORMING PROCEDURE: Dr. K. TRAVNICEK ANESTHESIA: ☐ IVCS ☐ MAC ☒ LOCAL INFILTRATE ☐ GENERAL ☐ OTHER

☐ ANESTHESIOLOGIST ☒ IVCS NURSE V. RIZZARDI RN CIRCULATOR C. BUHTZUNG, RN

MED NURSE A. REUSCHEN, RN ☐ N/A SCRUB L. PARKS X-RAY S. SCIRE OTHER _____

MEDICATIONS GIVEN BY PHYSICIAN DURING THE PROCEDURE:

☐ 1% Lidocaine MPF ☒ 0.5% Bupivacaine MPF ☐ 0.9% Normal Saline ☒ Omnipaque 300 mg plain

☒ 2% Lidocaine MPF ☒ Dexamethasone ☐ Myoblock ____ Units ☐ Omnipaque 300 mg Added ☐ Ancef ____ mg

☐ 4% Lidocaine MPF ☐ Methylprednisolone ☐ Pump medication verified with attending MD

(The dose and route of the medications given are noted on the procedural report of the physician performing the procedure.)

PRE-OP DIAGNOSIS: LUMBAR SPONDYLOSIS

PROCEDURE: [ ] Cervical [ ] Thoracic ☒ Lumbar [ ] Caudal [ ] Hip [ ] Knee [ ] Shoulder (Number multiple procedures in sequence)

[ ] Discography

[ ] Epidural Steroid Injection

☒ Facets: [ ] Right [ ] Left ☒ Bilateral

[ ] Intercostal Nerve Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Medial Branch Block: ☒ Right [ ] Left [ ] Bilateral

[ ] Occipital, Greater/Lesser: [ ] Right [ ] Left [ ] Bilateral

[ ] Radiofrequency: [ ] Right [ ] Left [ ] Bilateral See RF Neurotomy Procedural Notes Form

[ ] Sacroiliac Joint: [ ] Right [ ] Left [ ] Bilateral

[ ] Selective Nerve Root Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Stellate Ganglion: [ ] Right [ ] Left [ ] Bilateral

[ ] Sympathetic Block, Lumbar [ ] Right [ ] Left

[ ] Transforaminal epidural steroid injection: [ ] Right [ ] Left [ ] Bilateral

[ ] Trial Spinal Cord Stimulator [ ] Trial Pain Pump [ ] Other _____

Prep to operative site: ☐ Duraprep ☒ Chloraprep: ☐ Tinted ☒ Clear **By:** L. PARKS

Positioning: ☐ Supine ☒ Prone ☐ Lateral ☐ Arms tucked ☒ Pillows for positioning

☐ Padded toboggans used for arm protection ☒ Safety strap on x 3

POST-OP DIAGNOSIS ☒ SAME ☐ Other _____ ☐ Pain log given

Notes: _____

☐ Radiation Skin Status - Pre Radiation ☒ All Clear Post Radiation ☒ All Clear

CIRCULATOR SIGNATURE C. MANNING, KN

Valley View Surgery Center

Pain Management OR Record

Dr. K. Travnicek

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

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JS533

snider

Pre-Op Visit BP 140/81 HR 48 RR 16 O_2 Sat 96 % ☐ Room air ☐ Oxygen @ ___ L/min Temperature 96.6 °F

ALLERGIES ☐ NKA ☐ See Front of Chart

	Time	1000	1005	1010													
Legend: v = Systolic BP, ^ = Diastolic BP, • = Pulse	220																
	210																
	200																
	190																
	180	✓	✓														
	170			✓													
	160																
	150																
O_2 Appliance: ☐ Cannula ☐ Mask	140																
O_2 Liter Flow @ ___ L/min	130																
ECG: ☐ NSR	120																
☐ Sinus Bradycardia	110																
☐ Sinus Tachycardia	100																
☐ Other:	90		^	^													
IV Site: ☐ Right arm	80																
☐ Left arm	70	^															
☐ Other:	60																
Condition: ☐ Patient	50	•	•	•													
☐ Other:	40																
Solution: ☐ Saline Lock	30																
☐ Isolyte ☐ 0.9% NaCl	SaO_2	100	100	100													
☐ Other:	RR	16	16	16													
Acceptable range 35-45mmHg	ETCO2	38	38	38													
ETCO2 Waveform present ✓		✓	✓	✓													
CONSCIOUS SEDATION SCALE																	
Respirations: 0. Appear Adequate 1. Impaired exchange 2. Dyspnea/Obstructed		0	0	0													
Level of Consciousness: 0. Alert or awakening 1. Follows commands / Intermittent arousal 2. Unresponsive		0	0	0													
Vital Signs: 1. Increase (+ 21% of pre-anesthetic level) 2. Within acceptable limits 3. Decrease (- 21% of pre-anesthetic level)		2	2	2													
Physical / Emotional Affect: 0. Restless / Intense / Anxious / Uneasy 1. Fatigued or Intermittent response/Calm / Tolerant 2. No response		1	1	1													
Total Sedation scale (Optimal 3-5)		3	3	3													
MEDICATIONS																	
☐ Versed IV mg																	
☐ Fentanyl IV mcg																	
☐ Alfentanil IV mcg																	
☐ Propofol IV mg				No sedation													
☐ Romazicon IV mg																	
☐ Narcan IV mg																	
☐ Cefazolin IV mg																	
☐ Other:																	

IVCS RN Printed Name: VIRIZARI **Signature:** V. Virizari **Initials** VV

Antibiotic: ☒ NA ___ **completed at** ___ **By** ___

☑ Patient tolerated procedure well and was transferred to PACU in apparent good condition.

☑ Report given by IVCS/circulating nurse and care handed over to **PACU Nurse** J. Chandler RN

VALLEY VIEW SURGERY CENTER
IVCS by RN

Patient Label
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

M:\FORMS\Clinical forms\017A IVCS by RN.doc rev 100413 fd

JS534

Nursing Diagnosis	Outcome Goal	Plan	Interventions/Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure	Ensure immediate , on-site availability of back-up personnel for airway management, resuscitative emergency intubation and emergency equipment	Emergency equipment will be present, working properly and immediately available in the room where the procedure(s) are performed Nursing assessment conducted by IVCS nurse including pertinent medical history, verification of allergies, confirmation of NPO status	
Potential decrease in blood pressure, heart rate, peripheral resistance and oxygen saturation, especially during administration of sedation agent(s)	Patient vital signs will remain within patient's normal limits as evident by the utilization of monitoring equipment peri-operatively	Explain monitoring equipment and ECG pads to patient	ECG electrodes, blood pressure cuff and pulse oximeter applied prior to procedure Vital signs will be monitored continually throughout the procedure at a minimum before the start of procedure, one minute after administration of medication(s) given, and at least every five minutes thereafter until procedure is completed	
Potential for anxiety and pain related to therapeutic and/or diagnostic procedures	Patient will be able to tolerate diagnostic and/or therapeutic procedures with reduced anxiety and discomfort. Patient's LOC will be mildly depressed with an altered perception to pain, but will retain the ability to respond appropriately to verbal and/or tactile stimulation	Sedation agent(s) will be administered per physician's orders	Pts LOC will be assessed at regular intervals, verbal reassurance will be given to divert patient's attention and assist in reducing anxiety	Initials:

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Date: 3/9/17 Monitors On ☑ Alarms Set ☑ Allergies: ________ ☑NKA

Procedure: (B) L F J Inj ☐ See Front of Chart

PreOp: B/P 140/81 Pulse 48 RR 16 SaO₂ 96 % ☑RA ☐ @ ___ L/min Temp: 96.8 Pain Level: 6/10 Initials S

ADMIT TIME	BP	PULSE	RESP	O2 SAT	O2 L/MIN	TEMP	PAIN LEVEL	POSTANETHESIA ASSESSMENT RECOVERY SCORE	ADMIT	DISCHARGE
1015	137/78	48	18	99		96	5/10	Purposeful movement of all extremities =2 Moves two extremities =1 Activity No movement of extremities =0	2	2
1020	139/90	48	16	96			5/10			
1025	131/92	48	18		97		5	Breath deeply and cough freely =2 Limited and/or impaired breathing =1 Resp Apnea =0	2	2
								BP stable or improved over PreOp readings. Pt. asymptomatic = 2 Pt. outside of acceptable range based on PreOp readings. =1 Circ Unstable Hypotension or Hypertension = 0	2	2
								Alert, fully awake, responding appropriately =2 Responds to name and/or verbal stimuli =1 LOC Unresponsive =0	2	2
								Normal skin color/SpO₂ > 92% on room air = 2 Pale, Supplemental O₂ for SpO₂ > 90% =1 Color SpO₂ < 92% with O₂ supplementation =0	2	2
								Totals:		
								DISCHARGE CRITERIA:SCORE 10 or pre anesthesia	10	10

TIME	MEDICATION/DOSE/ROUTE/SITE FOR IM OR SQ INJECTIONS	PAIN LEVEL	INITIALS
Ø			

NURSES NOTES (Must make comments for "outcome discharge answers)

☐ Pt. given pain log and understands instructions as noted by pt.'s verbalization. ☐NA

☐ Time: 1142 Pt. up in wheelchair. Medically discharged. Waiting for ride.

Signature		Initials	
Signature	[signature]	Initials	9C

DISCHARGE

Pt. tolerated procedure without apparent injury: ☐ Yes ☐ No*

Safety maintained: ☐ Yes ☐ No*

LOC: ☑ Alert ☐ Oriented same as PreOp level ☐ Sedated* ☐

☐ Nausea/Vomiting ☐ NA ☐ Minimal/Not treated ☐ Treated

Intake: PO 60 mls IV Ø mls

Discharge Criteria Met: ☑ Yes ☐ No*

IV catheter removed / catheter intact ☑ Yes ☐ No*

S/S of complications due to IV: ☑ No ☐ Yes*

Copy of post op instructions given to pt./other: ☐ Yes ☐ No*

Prescription given: ☐ NA ☐ Yes If yes, instructed pt. to take medication as written on prescription ☑ Yes ☐ No

Instructed pt. to resume medications as instructed / ordered by MD. ☑ Yes ☐ No

Pt./other states understanding of all instructions: ☑ Yes ☐ No*

Mobility unchanged from Pre Op level: ☐ Yes ☑ No*

Discharged via w/c to responsible adult: ☑ Yes ☐ No*

Discharge Pain Level: 0 Discharge Time: 1144

VALLEY VIEW SURGERY CENTER

POST PROCEDURE RECORD

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

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JS536

POST-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Altered airway Function Post-anesthesia	• Observe & maintain or support airway as needed • O_2 on arrival / PRN • Monitor SaO_2 • Appropriate position	Patient airway with maximum respiratory compliance as evidenced by adequate O_2 exchange, tissue perfusion & visible hemodynamics. Clear airway without assist	Goal is obtained: ☐ Yes ☐ No Comments:
Altered hemodynamics potential for hypovolemia	• Monitor EDG for arrhythmia • Note/intervene for B/P +/- 50% of pre-op reading • Observe surgical site for bleeding	Stable hemodynamics	Goal is obtained: ☐ Yes ☐ No Comments:
Altered level of consciousness	• Stimulate adult patient PRN • Do not stimulate pediatric patient if airway & hemodynamics are stable • Orient patient to surroundings • Observe for altered L.O.C.	Patient will be arousable, oriented and as alert as possible prior to discharge	Goal is obtained: ☐ Yes ☐ No Comments:
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety. Able to verbalize pos-op instructions (i.e. diet, wound care, pain control & activity)	Goal is obtained: ☐ Yes ☐ No Comments:
Potential injury	• Utilize side rails (pads PRN) • Place bed in low position • Secure IV's and assess for patency • Ensure correct physiological positioning	No injury in PACU	Goal is obtained: ☐ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Relief of pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments:
Nausea & Vomiting ☐ N/A	• Recognize nausea • Medicate as ordered • Teach relaxation techniques • Position for comfort & to prevent aspiration	Relief of nausea verbalized	Goal is obtained: ☐ Yes ☐ No Comments:

Initials of Nurse

Nurses Notes Continued as needed:

If EKG strip affixed to record, complete the following:

Time _____ am/pm

Dr. _____ notified @ _____ am/pm

Per MD's order: ☐ No treatment
☐ Treatment: _____

Signature of RN: _____ Time: _____ am/pm

NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Date: 3/9/17 Time Admitted: 0910 **PRE-OP CHECKLIST** 702-525-9001

Pt. identified by ☑ full name ☐ date of birth by S From: ☐ Home ☐ Other _____ Via: ☑ Walking ☐ Wheelchair ☐ Carried

Planned Procedure: R Lap L5-S1 FJT NPO since: 2200 AM Meds: ☐ Yes ☑ No

Responsible Adult taking pt. home: Daughter/Driver: Marisa ☐ Same ☐ Waiting ☑ Call at: [illegible]

MEDICAL HISTORY: ☐ Asthma ☐ Ulcers ☐ Hiatal Hernia ☐ TMJ ☐ SOB ☑ Diabetes ☐ MVP ☐ Stroke ☐ Sleep Apnea ☐ Hepatitis ☐ Hypertension ☑ Smoker ☐ Chest Pain/Previous MI (Date_____) ☐ Palpitations ☐ Seizures ☐ Back/Neck Problems ☐ Thyroid Problems ☐ AIDS/HIV Positive ☐ Street Drugs ☑ Arthritis ☑ Osteoporosis ☐ Other/Notes: _____

SURGICAL HISTORY: ☐ Tonsils/Adenoids ☐ Gallbladder ☐ Hysterectomy ☐ CABG ☐ Hernia ☐ Appendix ☐ Back ☑ Hip ☐ Sinus/Nasal ☐ Biopsy _____ ☐ D&C ☑ Laparoscopy ☐ Metal Implants ☐ Pacemaker/ICD ☐ Foot ☐ Cervical ☐ Knee ☐ Eye Surgery ☐ Other/Notes: OR 22.

Medication list: See Pre-Anesthesia Record and Patient Home Medication List

VITAL SIGNS: Weight 94 Kg Ht Height 66"

SAO2 96 % ☑ RA @ _____ L/min Temp 98.2 Pulse 98 Resp 16

BP 140/81 ☐ R ☐ L arm Extremity temp: R _____ L _____ ☐ NA

ALLERGIES: ☑ NKA _____ ☐ See Front of Chart

SYSTEMS ASSESSMENT ☑ or ☑ = Fall Risk If ≥4 ☑ or ☑ checked ☑ Fall Risk Band applied

Respiratory:
- Respiration: ☑ unlabored ☐ labored ☐ other _____
- Breath Sounds: ☑ audible ☐ clear ☐ other _____
- Cough: ☑ absent ☐ non-productive ☐ productive ☑ other Smoker.

Cardiovascular:
- Heart tones: ☑ regular ☐ irregular ☐ other Bradycardia, denies dizziness
- Color: ☑ pink ☐ cyanotic ☐ other @ rest/palpitations/CP.

Neuro Sensory:
- ☑ alert ☑ oriented ☑ confused ☐ other _____
- Psychosocial: ☑ calm ☑ anxious ☐ crying ☐ angry ☑ other Tearful
- Skin: ☑ normal ☐ pink ☐ cyanotic
- ☑ warm ☐ cool ☑ dry ☐ diaphoretic ☐ other _____
- GI / GU: ☑ normal ☐ incontinent ☐ other _____
- Activity: ☑ full ☐ ROM ☑ uses assistive device ☑ Fall within 3 mo ☐ other _____
- *Pain Intensity Level: 0/10 Location: Back / Leg Pain Quality Achy

CHECKLIST	Yes	No	NA
Consent	✓		
H&P			
H&P (Podiatry)			
CXR			
EKG			
CBC			
Coag.			
Urine			
Lytes/Chem panel			
Preg Urine/Serum			
Hepatitis Screen			
HIV			
Bowel prep finished			
Surgical Site Clipped			
Medical Clearance			
TEDs/SCDs			

TESTING ON UNIT	RESULTS	N/A
Urine Pregnancy	Neg.	✓
AccuChek		
☐ FBS ☐ RBS		✓
Normal range FBS 70 – 200 mg/dL		

PREMEDICATIONS:

Times	Medication / Dose	By

Pre-Op teaching done ☑ Yes ☐ No

Discharge Inst. given ☑ Yes ☐ No

Patient ride confirmed ☑ Yes ☐ No

Valuables w/	Patient	Family	None
Dentures	✓		✓
Glasses/Contacts			✓
Hearing aids			✓
Clothes	✓		
Jewelry/ Body Jewelry	*See back		✓

Procedure or surgery site:

☑ Confirmed w/pt: ☐ right ☐ left ☑ bilateral ☐ NA

☐ Marked by MD

IV started in holding: ☑ Yes ☐ No Attempts _____ Initial S

Flush: ☑ 3 mls NS ☐ IV _____ ☐ _____ mls

Site: ☐ R ☐ L ☐ Superior Dorsal ☐ Anticubital vein

☐ Other: _____ Gauge ☐ 18 ☐ 20 ☐ 22 ☐ 24 Exp: _____

ID band applied by: S

☑ Pt. tolerated tx. ☐ Other _____

SIGNATURES (Initial)

Diana Shelf (✓)

( )

To OR via: ☐ gurney ☐ side rails up ☐ bed ☐ low ☐ carried ☑ walk in

Valley View Surgery Center

PRE-OP CHECKLIST

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Path NAME: SEKERA, JOYCE P JS538
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

PRE-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety	Goal is obtained: ✓ Yes ☐ No Comments:
Potential Injury	• Utilize side rails (pads PRN) • Place bed in low position/chair locked • Secure IVs & assess for patency • Ensure correct physiological positioning	No injury in Pre-Op	Goal is obtained: ✓ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Pain verbalized using pain scale	Goal is obtained: ✓ Yes ☐ No Comments:

Pre-Op Nurse Initials S

NURSE'S NOTES

*Confirmed/witnessed with pt.: Jewelry secured in closed plastic bag. Bag placed in pt.'s belonging bag.

Nurse's Initials AAe Last-S.

TIME	
	"Im afraid of Anesthesia Because when I 22 I had a Lapromscopy. The gas cause pain in my ABD - I had to have A Massage, massages, 7 days in the hospital." Unsigned

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Reference: AAAHC Institute for Quality Improvement, *Patient Safety Toolkit: Ambulatory Surgery and Preventing Falls*, 07/22/13

JS539

Height / Estatura 66" Actual weight / Peso _____ lb.

Allergies: / Alergias: N/A.

1. Have you taken any of the following medications:
Ha tomado los medicamentos listados:

- Aspirin: ☐ Yes, date last taken / Aspirina: ☐ Si, ultima fecha tomada _____ ☑ No
- Plavix: ☐ Yes, date last taken / ☐ Si, ultima fecha tomado _____ ☑ No
- Coumadin: ☐ Yes, date last taken / ☐ Si, ultima fecha tomado _____ ☑ No
- Anti-inflammatory: ☐ Yes, date last taken / Anti-inflamatorios ☐ Si, ultima fecha tomado _____ ☑ No

2. For female patients only:
Date of last menstrual period_____ ☐ N/A
Para mujeres solamente: fecha de su ultima menstruación_____

3. List all previous surgeries (and when)
Lista de todas cirugías previas (con fechas)

4. Do you symptoms of tuberculosis
Ha sido diagnosticado con Tuberculosis-

-Productive cough / -Tos productiva	☐ Yes ☑ No	-Weakness, Fatigue / -Fatiga, debilidad	☐ Yes ☑ No
-Bloody sputum / -Esputo con sangre	☐ Yes ☑ No	-Night sweats / -Sudores nocturnos	☐ Yes ☑ No
-Unexplained weight loss / -Perdida de peso inexplicable	☐ Yes ☑ No	-Fever / -Fiebre	☐ Yes ☑ No

HISTORY / HISTORIAL	Yes / Si	No
5. Have or are you taking "street drugs" **If yes, last date**_____ Ha o está tomando drogas ilegales En caso que si, fecha ultima: _____	☐	☑
6. Do you use Medical Marijuana? **If yes, last date:**_____ Utilizas la marihuana medicinal En caso que si, fecha ultima:_____	☐	☑
7. Have you had recent weight change? (Significant amount) Has tenido cambio significante en peso		

HISTORY / HISTORIAL	Yes / Si	No
8. Do you smoke? **If yes, cigarettes per day:** 4 ¿Fuma? En caso que si, cuantos cigarrillos per dia ___	☑	☐
9. Do you have caps, false teeth, bridge, partials or contact lenses? ¿Tiene dientes falsos, tapas, dentaduras/Puente parsial o lentes de contacto	☑ (Molar's Extracted)	☐
10. Do you drink alcoholic beverages? **If Yes, how much** _____, **last time**_____ ¿Consume bebidas alcolicas? En caso que si, cantidad _____	☐	☑
11. Have you ever experienced any reaction to rubber or latex products? Alguna vez ha experimentado una reacción a los productos de goma o látex **If yes, please describe** En caso que si, por favor describa	☐	☑
12. Glaucoma Glaucoma	☐	☑
13. TMJ (dysfunction of temporomandibular joint) TMJ (disfunción de la articulación temporomadibular)	☐	☑
14. Stiff neck Cuello tieso	☐	☑
15. Shortness of breath Dificultad para respirar	☐	☑
16. Asthma Asma	☐	☑
17. Heart attack Ataque de Corazón	☐	☑
18. Chest pain; angina Dolor de pecho	☐	☑
19. Palpitations Palpitaciones	☐	☑
20. High blood pressure Alta presión	☐	☑
21. Implanted pacemaker/defibrillator Marcapasos / desfibrilador	☐	☑

CONTINUE ON BACK
CONTINUAR EN LA PARTE POSTERIOR

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS540

HISTORY HISTORIAL	Yes Si	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☐
23. **Hepatitis** Hepatitis **If Yes /** En caso que si **Type** ☐ A ☐ B ☐ C	☐	☐
24. **Hiatal Hernia** Hernia Hiatal	☐	☐
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** _____ ¿En caso afirmativo, cuando? _____	☐	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☐
27. **Ulcers** Ulceras	☐	☐
28. **Stroke** Derrame Cerebral	☐	☐
29. **Seizures** Convulsiones	☐	☐
30. **Parkinson disease** Enfermedad de Parkinsons	☐	☐
31. **Blackouts** Desmayos	☐	☐
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☐
33. **Back / Neck Problems** Problemas de cuello / espalda	☐	☐
34. **Osteoporosis** Osteoporosis	☐	☐
35. **Muscle Diseases** Enfermedad Muscular	☐	☐
36. **Arthritis** Artritis	☐	☐
37. **Diabetes** Diabetes	☐	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☐
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☐
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☐
41 **Blood Transfusion** Transfusión de sangre	☐	☐
42. **Kidney Disease** Enfermedad de Riñones	☐	☐
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que Si, fecha de ultimo tratamiento?	☐	☐

HISTORY HISTORIAL	Yes Si	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☐
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☐
46. **Metal Implants** Inplantes Metálicos	☐	☐
47. **Cancer** **If Yes, Where**_____ Cancer En caso que Si, en donde_____	☐	☐
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☐
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☐
50. **Draining wound** Herida abierta	☐	☐
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☐
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☐

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

_____
Signature (Patient/ or Person filling out form)
(If other than patient; relationship :_____)

_____
Firma (Paciente/representante)
(relación al paciente: _____)

3-9-17
Date/Fecha

_____ 3/9/17
Signature of Pre Op Nurse — Date

☐☐ = Fall risk

JS541

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Valley View Surgery Center

PATIENT HOME MEDICATION LIST (As Provided by Patient)

Please fill in highlighted areas only and bring form back to VVSC before or on the day of your procedure

□ No Known Allergies

ALLERGIES AND THEIR REACTIONS:

List all medications taken over the past 6 months (include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment.)

Medication Name	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: 3/9/17 Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)
None							

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR	□**New Rx given to pt. Copy in MR

=Pre-Op Nurse Signature
* Complete Medication Information Unknown by pt. = CMI Unk

¥ Is PACU Nurse Signature
** ☒Check box if pt./cg instructed on medication use, common side effect, and aftercare upon discharge.

=	=	=	=
*□CMI Unk	*□CMI Unk	*□CMI Unk	*□CMI Unk
¥	□ ¥	□ ¥	□ ¥
□Copy of med list given to pt. on DC.	□Copy of med list given to pt. on DC	□Copy of med list given to pt. on DC	□Copy of med list given to pt. on DC

******** Contact your prescribing physician for questions regarding any medications listed on this page********

NAME: SEKERA, JOYCE P
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PATIENT LABEL | PATIENT LABEL | PATIENT LABEL

rev 010917 PP.doc

JS542

VVSC Surgical/Procedural Safety Checklist

Note: Patient is patient himself/herself or legal representative or surrogate	Pre-Op	OR	PACU
1. Ensure a clean and sanitary environment for each patient.	S	CM	CM
2. Patient identified as per VVSC policy & ID Band is on patient	S	CM	CM
3. Allergies/ adverse reactions verified and stated on front of chart	S	CM	CM
4. Surgery/Procedure Consent: Operative Procedure & site verified with patient	S	CM	
a. Patient's Signature	S	CM	
b. Witness Signature	S	CM	
5. Anesthesia Consent:	S	CM	
a. Patient's Signature	S	CM	
b. Anesthesia Provider (Anesthesiologist or MD performing procedure) Signature	S	CM	
6. H & P – to include heart and lung (Noted on Pre-Op checklist form)	S	CM	
7. Pre-Op MD Orders	S	CM	
a. As ordered, pre-op test(s): ☐ Completed, results reviewed and placed in chart ☐ Not present, action taken (See pre-op checklist nurse's note) ☑ N/A	S	CM	
b. Standing Orders to draw blood sugar and /or urine pregnancy test ☑ N/A	S		
c. Actions if blood sugar is out of range. Noted on back of Pre-Op Checklist and in blood sugar result log ☑ N/A	S		
d. Antibiotic as ordered: ☐ Initiated ☐ Completed ☑ N/A	S	CM	
e. *Any special equipment, devices, implants ☐ Yes ☑ N/A	S	CM	
8. Procedure Site: MD marked Operative site ☐ Yes ☑ N/A	S		
9. Pre-Op Anesthesia/Nurse Assessment Form / Medication List	S		
a. Patient Signature	S		
b. Nurse Signature	S		
c. Medication list has dosage, frequency, date last taken. If pt. doesn't know, document	S		
Any G-Code occurrences? ☑ No ☐ Yes List G-Code _____ See back of sheet for	S		
10. IntraOp or Intra Treatment: Ensure a clean and sanitary environment for each patient			
11. Intra Operative briefing before procedure started: *Time-Out* performed per policy, allergy status and other concerns discussed- *difficult airway or aspiration risk or aspiration risk, risk of blood loss if applicable			
12. *Procedure site is marked and visible ☐ N/A			
13. *Relevant images properly labeled and displayed ☐ N/A			
14: *De-briefing after completion of procedure			
a. Name of procedure performed			
b. Sponge, sharp count performed ☑ N/A			
c. Specimens identified and labeled ☑ N/A			
d. *Any equipment problems to be addressed ☑ N/A			
e. *Key concerns for recovery and management of this patient ☑ N/A			

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NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
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DOS: 03/09/17 SEX: F

	Pre-	OR	PACU
15. Sterilization Documentation completed/initialed			
16. O. R. Record Complete with out of OR time			
# 10 to #16 completed by			
Any G-Codes occurrences? ☐No ☐Yes List G-Code_____ See below for references			
17. Ensure a clean and sanitary environment for each patient			
18. Admit time to PACU			
19. Post Op Orders Noted			
20. Signature of Discharging MD for anesthesia recovery Discharge time on PACU record			
21. Discharge time to home or transfer to hospital noted ☐Yes			
22. Copy of VVSC's prescriptions ☐Yes ☐ N/A			
23. Name of responsible adult pt. discharged to noted on discharge instructions			
24. Phone number of the physician doing surgery or procedure on discharge instructions			
Any G-Codes occurrences? ☐No ☐Yes List G-Code_____ See below for references			

Nurse Name: **Printed**	Signature:	/ Initials:
Nurse Name: **Printed**	Signature:	/ Initials:
Nurse Name: **Printed** C. MATTSON, RN	Signature:	/ Initials: CM
Nurse Name: **Printed**	Signature:	/ Initials:
Nurse Name: **Printed**	Signature:	/ Initials:
RN Co-sign for LPN: **Printed**	Signature:	/ Initials:

ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE First and last name initials signify the nurse has completed the listed responsibility. "O" with Initials next to it signifies the nurse assessed the responsibility and completion is needed.*Revision/Additions to this form adopted from AORN Comprehensive Surgical Checklist that incorporated WHO, Joint Commission-Universal Protocol (JC) 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	**G8908** Patient documented to have received a burn prior to discharge
Patient Fall	**G8910** Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	**G8912** Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	**G8914** Patient documented to have experienced hospital transfer/admission
Prophylactic IV Antibiotic Timing	**G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
	G8917 Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.

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NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56 SEX: F
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17

2

I consent to the admission to Valley View Surgery Center (VVSC) for my treatment(s) and authorize VVSC, staff, and doctor(s) to provide care. I authorize and direct **DR. TRAVNICEK** to perform the following treatment(s) or any other treatment deemed necessary at the discretion of the physician:

BILATERAL LUMBAR FACET JOINT INJECTIONS WITH THE USE OF FLUOROSCOPIC GUIDANCE

Physicians providing services at VVSC are not agents or employees of VVSC.

I understand I have the right to be informed. My physician has explained the treatment(s) necessary to treat my condition, purpose of the treatment and its associated anticipated benefits, including but not limited material risks, and alternative methods of treatment and its associated anticipated benefits, including but not limited material risks. No guarantee has been given as to the results that may be obtained. I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results. I have the right to be informed of the likelihood of success and the problem(s) associated with recuperation and the possible results of non-treatment. I have the right to request/consent to or to refuse any proposed treatment at any time prior to its performance.

I have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation/procedure. I have the right to be informed if any professional relationship to another health care provider or institution that may suggest a conflict of interest exists.

If applicable, I authorize the administration of anesthesia from an anesthesia provider as may be deemed necessary for the treatment.

My signature below authorizes the pathologist to use his/her discretion in disposing of any tissue removed from my person during the treatment(s) described above. I authorize x-rays, photographs, or videotaping for diagnostic or medical education purposes including utilization of medical residents, students, and/or manufacturing representatives.

I authorize to the drawing of a blood sample from my body in the event that an employee or physician of the surgery center has an accidental puncture or mucous membrane (eye, mouth, etc) exposure to my blood or body fluids. The blood samples will be tested for HIV and Hepatitis. No results of any tests done on my blood will be released or shown to any unauthorized person without my written consent.

My signature on this form indicates that I have read and understand the information provided on this form, that the treatment(s) described above has been adequately explained to me by my physician, that I have had the opportunity to ask questions, that I received the information I desire concerning the treatment, and that I consent and authorize to the performance of the treatment(s) upon myself.

I understand and agree that I am solely responsible for maintaining the privacy of my protected health information in the paperwork I received.

I have not eaten or drank since (Date& Time) 220 ☐Fluid, _____ (am't), ☑Solid 3/8/17 2200
I have a responsible adult to drive me home.

☒ Joyce Sekera
Patient's Signature or Patient's Representative or Surrogate
Relationship to Patient: ☑Self ☐Other

3/9/17 Date 0910 Time

Signature of person witnessing the patient's or patient's legal representative signature

3/9/17 Date 0910 Time

☒ Verified consent CM/RN Initials of circulator

<SEKERA, JOYCE>

JS545

Valley View Surgery Center

Treatment Consent/Authorization

M:\Consents - Pain Mgmt\TRAVNICEK CONSENTS\2017-3-9 TRAVNICEK consents.doc

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Patient Consent for Anesthesia at Valley View Surgery Center

I understand:

I will need anesthesia services for the surgery/procedure to be done today,

- And the amount of anesthesia to be used will depend upon the procedure(s) and my physical condition. Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical/surgical procedure.
- During the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
- Although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are a part of the risks I must consider in deciding to have a procedure. Some of the unusual risks and complications of anesthesia may include but are not limited to allergic or adverse reactions, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/by others, seizures, sore throat, and death.
- A detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to inform me. No guarantees have been made by anyone regarding the anesthesia services which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS:

Patient Initials	
_____	☐ **General Anesthesia**: 1. Mask Anesthesia- Gases are passed through a mask which covers the nose and mouth or 2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth or 3. Laryngeal/Mask Anesthesia- Gases are passed through a mask placed behind the tongue which covers the larynx (voice box) or 4. Deep sedation.
_____	☐ **Regional Anesthesia** 1. Nerve block-Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.
_____	☐ **Monitored Anesthesia Care (MAC), Total Intravenous Anesthesia (TIVA)** - The anesthesiologist monitors blood pressure, oxygenation, pulse, and mental state and supplements sedation and analgesia as appropriate.
_____	☐ **Local Anesthesia** 1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedure site. 2. Topical Anesthesia- Surface anesthesia is produce by direct application of anesthetizing agents on skin or membrane.
_____	☑ **Conscious Sedation by RN** - Involves the use of intravenous medication administered by licensed registered nurses under the direct supervision of the physician performing the surgery/procedure.

DNR ORDERS: I understand that DNR (do not resuscitate) orders will be suspended while I am in the procedure and until I completely recover from the effects of anesthesia.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to the acceptance of anesthesia might be no anesthesia for the procedure.

X _____ 3/9/17 0910

Patient's Signature or Patient's Legal Representative — Date — Time

_____ 3/9/17 0910

Signature of person witnessing the patient's or patient's legal representative signature — Date — Time

Valley View Surgery Center

Anesthesia Consent

Patient NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17
AGE: 60
SEX: F

JS546

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Next of Kin/*Pariente Proximo*:
Name/*Nombre*: Carole DiVito (Marissa Freeman) Relationship/*Relacion*: Mother - Daughter
Address and/or telephone number/*Domicilio o Numero de Telefono*: 702-525-9001

In Case of Emergency, I authorize VVSC to Contact:
En caso de Emergencia, yo autorizo a VVSC contactar a:
Name/*Nombre*: Marissa Freeman Relationship/*Relacion*: daughter
Address and/or telephone number/*Domicilio o Numero de Telefono*:

I authorize VVSC staff to discuss my medical care with / *Yo autorizo al personal de VVSC para discutir mi cuidado medico con:*
Name of person(s) / *Nombre de persona (s)* Marissa Freeman/Carole DiVito

Advanced Directive / *Directivas Anticipadas*: (not applicable for patients under 18 years of age / *no es aplicable a pacientes menores de 18 años*)
Information regarding Advanced Directives is included in the Patient Information Packet /
La informacion sobre Directivas Anticipadas esta incluida en su paquete de informacion

_____ **I do** have an advanced directive / **Si tengo** *una Directiva Avanzada:*

- A copy is provided to VVSC: **Yes** **No** / *Se propociona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive /
  Yo entiendo que es mi responsabilidad informar a mis medicos de mi Directiva Anticipada.

✓ **I do not** have an advanced directive / **Yo no** *tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet/*Reconocimiento de paquete de informacion de paciente*:
As required by CMS (federal regulation), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (regulacion federal)h por escrito y la notificacion n verbal sobre los Derechos y Responsabilidades de los Pacientes, directivas anticipadas y la politica correspondiente de la instalacion, y una lista de los dueños del negocio de VVSC se dá a los pacientes. La firma debajo confirma que la a recibio por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☐ Received with previous date of service / *Recibido con la fecha anterior del servicio*

Joyce Sekera Date / *Fecha*: 3-9-17

Patient/Patient Representative signature (if other than patient; relationship:_____)

Valley View Surgery Center
Patient Acknowledgements

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Patient
NAME: SEKERA, JOYCE F
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS547

Patient Valuables and Belongings List

Jewelry	How Many?	With Family	With Patient	In Safe	Comments
Watch	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Ring (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Necklace (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Bracelet	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Earrings/Piercings	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Valuables					
Unopened Purse/wallet	[ ]	[ ]	[ ]	[ ]	
Keys	[ ]	[ ]	[ ]	[ ]	
Cell Phone	[ ]	[ ]	[ ]	[ ]	
ID Card	[ ]	[ ]	[ ]	[ ]	
Ins. Card	[ ]	[ ]	[ ]	[ ]	
Credit Card	[ ]	[ ]	[ ]	[ ]	
Check Book	[ ]	[ ]	[ ]	[ ]	
Money/Currency	[ ]	[ ]	[ ]	[ ]	Amount $________ [ ] Placed in enclosed envelope/secured VVSC safe.
Clothing					
Blouse/ Shirt	[✓]	[ ]	[✓]	[ ]	
Pants/Shorts	[✓]	[ ]	[✓]	[ ]	
Coat/Sweater Jacket	[✓]	[ ]	[✓]	[ ]	
Dress/Skirt	[ ]	[ ]	[ ]	[ ]	
Shoes/Slippers/Socks	[✓]	[ ]	[✓]	[ ]	
Hat/Belt/Vest	[ ]	[ ]	[ ]	[ ]	
Bra/slip/ Undergarments	[✓]	[ ]	[✓]	[ ]	
Equipment					
Cane/Walker/ Crutches	[ ]	[ ]	[ ]	[ ]	
Wheelchair/ Scooter	[ ]	[ ]	[ ]	[ ]	
Other	[ ]	[ ]	[ ]	[ ]	
*Eyeglasses/ Sunglasses	[ ]	[ ]	[ ]	[ ]	*In labeled Ziplock bag
Dentures/partials	[X] N	[ ]	(✓)		

Patient Agreement at the time of Admission and Discharge

I understand that Valley View Surgery Center is NOT responsible for my personal belongings. I understand that I have been advised to leave my jewelry/valuables at home or with my responsible adult At VVSC.

PreOp

Patient/Representative (if patient is unable to sign): *[signature]

RN Witness: [signature] **Date:** 3/9/17

PACU/Discharge

Patient/Representative (if patient is unable to sign): [signature]

By signing, I attest that I was sent home with all belongings as stated above.

[ ] RN [ ] CNA Witness: [signature] **Date:** 3-9-17

Valley View Surgery Center

Patient Valuable and Belongings

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NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS548

☐ Your insurance has been verified for the procedures scheduled by your doctor.

- Confirm name insurance company/companies
- Notice of OON ☐ **N/A** ☐ **Primary Ins.** ☐ **Secondary Ins.**
- According to the information from your insurance company, the *estimate* of your financial responsibility for the *scheduled procedure(s)* is:

☐ Co-pay $0 (not an estimate)

☐ Deductible [redacted]

☐ *Estimate* of Co-insurance [redacted]

Total Due on DOS: $ DP-YEN

☐ **ABN Needed** **Total Amount:** $_____

☐ Did your doctor order any pre-op tests? If so, done? ☐ **Yes (where?)** ☐ **No** ☐ **N/A**

☐ **Verify Patient Demographics and insurance information**

☐ Patient Information Packet received at doctor's office?
If so, complete forms. If not, forms can be completed when arrive, bring list of meds.

☐ Confirm that patient is to follow the instructions received for doctor's office:

- Arrival time
- Nothing to eat or drink for time prior to admit

☐ Confirm knowledge of location of VVSC

☐ Bring with you:

- Photo ID and insurance cards
- List of current medications, prescription and over the counter, including vitamins for the past 6 months – Including dosage and last time taken.
- Payment as previously discussed
- A responsible adult to accompany you home.
- If you have an Advance Directive – bring a copy
- Leave jewelry, valuable at home.

Comments: NO PT KSP - ATTY/LIEN

☐ Spoke with Patient ☐ left message ☐ no answer

Chart Prepped by: _____

☐ Per AdvantX Comment, pt pre-registered, 2nd call not made due to $0.00 due

Date [redacted] called: 2/8/17 by: SJB

JS549

Valley View Surgery Center

Pre Operative Patient Call

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

\\VVSC-SVR01\LocalFolderRedirect\sbanks\Desktop\Pre op Patient Call [redacted]

Calculation of allowable charges and estimate of patient balance due on DOS

*First CPT code is the highest allowable + Second and all subsequent codes are 50% of Allowable
[Exception] *CIGNA* contract = 100%, 50% for second code and 25% for third and subsequent codes]
[Exception] *MDCD* contract = 100%, 50% for 2nd code, 25% 3rd code 10% for 4th and 5% subsequent codes]

CPT Code	Allowable	(Sierra) x 90%	+ 50% for second procedure	Total Allowable
* 64493	$ 123619			$ 123619
64493	$ 123618			$ 123618
Total Allowable for scheduled procedures:				$ 247237
Enter amount of deductible not satisfied:				
If Total Allowable is less than Deductible not satisfied, The Total Allowable is the total to collect on DOS				
If Deductible not satisfied is less than Total Allowable, subtract deductible from allowable and enter balance here:				
If there is an implant that is not included in the allowable, enter amount of implant:				
Add the above 2 boxes, Total:				
Multiply the Total above by _____ % of co-insurance:				

NAME: SEKERA, JOYCE P
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DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS550

The injection you received contained an anesthetic or an anti-inflammatory steroid medication or both. You could possibly experience a decrease in your pain, numbness and/or weakness due to the anesthetic. The numbness and/or weakness usually lasts 2-8 hours and can at times last longer (should not be longer than 24 hours). Upon the anesthetic wearing off, you may experience some pain at the injection site and/or a temporary increase in your everyday pain. The increase of pain should decrease as the anti-inflammatory medication starts to take effect. This usually takes 3 to 5 days or possibly longer. Ice packs can be used to treat pain and/or inflammation at the injection site although ice packs should NOT be used for more than 20 minutes at a time.

Please refer to your doctor's instructions for ALL PROCEDURES to include limitations of activities, changes with your medications and his/her specific requirements.

[ ] Call your physician's office to schedule a follow up appointment.

[ ] If you are diabetic and received a steroid injection, check your blood sugar twice daily for one week and call your internal medicine physician if your blood sugar is 250 or greater.

[ ] Call your physician's office/answering service if you have any of the following symptoms...

- > Severe headache and/or seizures.
- > Loss of ability to feel or move your arms or legs
- > Infection (redness, swelling, drainage or fever greater than 101.5 F)
- > Heavy pressure over the chest or palpitations (rapid heartbeat)
- > Bleeding at the injection site that is not stopped within 15 minutes of direct pressure.
- > Difficulty breathing and/or speaking.
- > Adverse reaction to the medication given
- > Chills and/or sweating
- > Difficulty speaking and/or confusion

[ ] As ordered by your physician: You are to resume _____ in _____ days. [ ] N/A
Anticoagulant medication

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, CALL 911 OR GO TO THE NEAREST EMERENCY ROOM.

Dr. Travnicek
702-878-8252 :#

Due to the injection procedure as well as the sedation you received during the procedure, DO NOT operate machinery, drive a vehicle, use stairs, drink alcoholic beverages, engage in any strenuous activities until the numbness has completely worn off and your full strength has returned. Do not sign legal documents for at least 24 hours if you were sedated for the procedure.

SPECIFIC INSTRUCTIONS AND/OR EXPECTATIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

[ ] EPIDURAL INJECTION/ SELECTIVE NERVE ROOT BLOCK **[ ] INTRATHECAL INJECTION**
[ ] LUMBAR SYMPATHETIC BLOCK **[ ] FACET JOINT INJECTIONS** **[ ] DISCOGRAM**
[ ] SACRO-ILLIAC JOINT INJECTION **[ ] KYPHO/VERTEBRALPLASTY** **[ ] ALL OTHER PROCEDURES**

As mentioned above, you may experience weakness in the back, arms and/or legs depending on the injection as well as an increase in pain after the anesthetic wears off. You should relax for the remainder of the day.

[ ] MEDIAL BRANCH BLOCKS
This is a diagnostic procedure using an anesthetic. A steroid might also be used depending on your doctor's preference. You should return to normal activity, which usually causes your neck or back pain to see if the procedure effectively reduces or eliminates your pain. This will be temporary lasting only for hours. You should keep a diary/journal and record how much your pain has been reduced and for how long. Bring this diary/journal with you to your follow-up appointment.

[ ] STELLATE GANGLION BLOCK
It is normal for your eyelid to droop, facial droop, hoarseness, numbness and/or weakness in your arm or face on the side of the injection. These symptoms should subside in 4 to 8 hours. If you develop any "stroke like" symptoms, such as slurred speech, unable to speak, confusion or unable to move your arms or legs, call 911 immediately or go to the nearest emergency room.

[ ] TRIGGER POINT INJECTIONS **[ ] INTERCOSTAL/PERIPHERAL NERVE BLOCK**
If any shortness of breath occurs, please call your physician. In cases of moderate to severe difficulty breathing call 911 or go to the nearest emergency room.

[ ] RADIOFREQUENCY / RF / NERVE ABLATION DENERVATION
You may experience more pain or discomfort after the procedure when the anesthetic wears off. This increase of pain can last 1 to 2 weeks and should gradually reduce while the radiofrequency procedure takes effect.

[ ] TRIAL OR PERMANENT SPINAL CORD STIMULATOR **[ ] SPINAL (INTRATHECAL) PAIN PUMP**
Both your physician and the equipment company representative will provide you with information relative to the equipment and the procedure. Please follow the instructions provided by your physician and the representative.

[✓] Copy given to patient: DATE: 3/9/17 TIME: 0910 AM / PM

Patient's Signature _____ Witness Signature _____

Discharged to: Marisa Relationship: daughter

M:\pain\PAIN DISCH INSTRUCT 2016update.docx

JS551

Valley View Surgery Center
Discharge Instructions – Pain Management

Patient ID NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S Valley View Blvd
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: May 8, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED DIAGNOSTIC FACET JOINT MEDIAL BRANCH BLOCKS BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a styletted spinal needle was inserted percutaneously and directed to the lateral base of the superior articulating process at corresponding to each nerve to be anesthetized. Each site was then injected with contrast to confirm location and to rule out intravascular injection. Each site was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Alfentanil Midazolam
CONTRAST: Omnipaque
INJECTATE (each site): Lidocaine (pf) 2% fina concentration 0.5 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 5/08/2017 Time: 13:38:07

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS552

VALLEY VIEW SURGERY CENTER (VVSC) PATIENT REGISTRATION

Patient Information:

Name	Birthdate	Age	Sex	ACCT#
JOYCE P SEKERA	03/22/56	61	F	153654

Address	Race	Social Sec #	Marital Status
7840 NESTING PINE PL Las Vegas, NV 89143	Unknown	091488430	S

Home Phone: (702)467-5457 Cell Phone:
Employer: brand vegas Work Phone:

Guarantor: SEKERA, JOYCE P Patient's Relationship: Self
Address: 7840 NESTING PINE Las Veg NV 89143 Phone: (702)467-5457

Primary Insurance:

Carrier: LIEN PAYER Insured: SEKERA, JOYCE
Claims: ATTY; KEITH GALLIHER Patient's Relationship: Self Sex: F
Address DOB: 03/22/1956 SS#: 091-48-8430
1850 E. SAHARA #107 Insurance ID: 00000000000 Group #:
Las Vegas, NV 89104 Auth #: APPROVED
Ins. Phone: (702)735-0049 Employer: N/A

Secondary Insurance

Carrier: Insured: ,
Claims: Patient's Relationship: Sex:
Address DOB: SS#:
Insurance ID: Group #:
Auth #:
Ins. Phone: Employer:

Date of Surgery: 05/08/2017 Surgeon: TRAVNICEK, KATHERINE, M.D.

Procedure: BILAT 5-S1 INJECTION(S), DIAGNOSTIC Type of Service: Pain Management LUMB
PreOp DX: M54.5

Authorization for treatment: I hereby authorize treatment at Valley View Surgery Center
I hereby authorized and permit VVSC to release medical billing data relating to this service
Financial agreement and assignment of payment/benefits: I understand that I am financially responsible for all charges incurred regardless of insurance coverage. I hereby verify that the insurance information that I have provided is correct and that VVSC will bill my insurance for services received. I hereby assign payment of all surgical and/or medical benefits payable on my behalf to VVSC for services at VVSC, not to exceed charges. Any unpaid deductible and/or estimated co-pay is due and payable on the day of service. The account is expected to be paid in full within 90 days from the date of service.
In the event my account is referred to a collection service due to lack of payment on my part, I acknowledge that there may be additional collection/legal fees added to my account.

Returned check charge: I understand that if a payment by check is returned unpaid by my bank for non sufficient funds (NSF), there will be a NSF fee charged to my account not to exceed $50.00. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

Acknowledgement of receipt of HIPAA privacy notice information and Patient Rights & Responsiblities.

Received this date, Initial: JS Received previously, Initial: _____

Signed: Joyce Sekera **Date:** 5/8/17

Relationship if other than patient: _____

Witnessed by: FH

JS553

SCHEDULED PROCEDURE: Bilateral L5-S1 MBB

CHIEF COMPLAINT/ REASON FOR PROCEDURE:

- ☐ Head pain
- ☐ Neck pain
- ☐ Upper extremity pain
- ☐ Mid back pain
- ☑ Low back pain
- ☐ Sacral pain
- ☐ Lower extremity pain
- ☐ Other: _____

MEDICAL HISTORY: ☐ Other _____

See Pre-Anesthesia Record

Current medications – see Patient Home Medication List (Medication Reconciliation List)

HISTORY OF PREVIOUS PAIN MANAGEMENT PROCEDURE:

- ☐ No
- ☑ Yes

Justification for repeat Epidural Steroid Injection

- ☐ Partial Improvement
- ☐ Transient Improvement
- ☐ Significant Improvement
- ☐ Return of symptoms
- ☐ Persistent symptoms
- ☐ Other _____

SOCIAL/ FAMILY HISTORY:

- ☑ Non Contributory
- ☐ Other _____

ALLERGIES or ABNORMAL DRUG REACTIONS: ☑ NKA ☐ _____

PHYSICAL EXAM:

Heart/Cardiac _____

Lungs/Respiratory _____

Other _____

PLANNED ANESTHESIA:

- ☐ Anesthesiologist
- ☑ VVCS-RN ASA Score: ☐ 1 ☑ 2 ☐ 3 ☐ 4

PRE-OPERATIVE DIAGNOSIS:

☑ Spondylosis (facet pain)	☐ Cervical	☐ Thoracic	☑ Lumbar
☐ Spondylosis w/o myelopathy	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Displacement of intervertebral disc	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Degeneration Disc Disease	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Post Laminectomy Syndrome	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Other _____			

ABNORMAL FINDINGS TO BE ADDRESSED ON DATE OF SERVICE PRIOR TO PROCEDURE: ☐ NA

_____

_____ MD'S Signature ☐ Proceed ☐ Cancel procedure

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia. The Patient is cleared for procedure in VVSC.

DISCHARGE NOTE:

Complications ☑ None ☐ Other: _____

Condition Stable: ☑ Discharge to home

Physician signature: _____

Valley View Surgery Center

Pain Management History & Physical

Patient N
Patient

NAME: SEKERA, JOYCE P
ACCT: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS554

Date / Nurse Notation	Noted R. Gerold 050817 0140 **STANDING ORDERS**
	PRE-OP ORDERS: Admit to Valley View Surgery Center for scheduled procedure on consent.
	1. Urine pregnancy test on females having periodic menstrual cycles unless post hysterectomy or no menstrual period for more than a year. Results of Pre-Op blood or urine tests completed 7 days or less prior to procedure will be accepted for pregnancy screening.
	2. Obtain BP, Blood Sugar and HCG results (if applicable) on patients **prior** to having the patient change for the procedure.
	3. Do blood glucose level on all diabetic patients. Report results greater than 150.
	4. Insert 20G IV cath for Saline lock or IV solution. Flush w/ 3 mls 0.9% NS PRN. May use 0.5% Lidocaine 0.1-0.2mls subcutaneous before insertion. Start IV 0.9 NS 250 mls KVO on non-operative side for cervical procedures.
	5. -Discograms: Ancef 1000mg IVP/IVPB (Ancef 2000mgs IVPB for patients 120kg or greater) -Hardware Blocks, Implants, Plexus Block, Pump Refills, Superior Hypogastric Block, †TSCS and patients with history of MVP, and Subacute Bacterial Endocarditis: Clindamycin 900mg IV.
	7. For cervical transforaminal injections, give Ondansetron (Zofran) 4mg IVP over two to 5 minutes.
	8. For Stellate Ganglion and Sympathetic injections, record a baseline temperature on appropriate bilateral extremities.
	9. Document the date patient discontinued any of the following medications. Acceptable days of discontinuance from date of procedure: [ ]ASA–7days, [ ]Coumadin or [ ]Plavix- for7 days, [ ] Except for Celebrex, all non-steroidal anti-inflammatory medications for 4 days. Inform MD if days do not meet criteria.
	10. For blood patch procedures: Using sterile technique, insert at minimum a 20G IV catheter (preferable 18G) in the antecubital vein as the second IV site for blood draw
	Surgical Consent to read (CHECK ALL THAT APPLY):

CERVICAL———————— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection) ***
[ ] Stellate Ganglion [ ] Radiofrequency [ ] Discography [ ] Greater/Lesser Occipital
LEVELS: [ ]C2 [ ]C3 [ ]C4 [ ]C5 [ ]C6 [ ]C7 [ ]C8 [ ]C1-2 [ ]C2-3 [ ]C3-4 [ ]C4-5 [ ]C5-6 [ ]C6-7 [ ]C7-T1

THORACIC———————— [ ] Left [ ] Right [ ] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)*** [ ] Radiofrequency [ ] Discography
LEVELS: [ ]T6 [ ]T7 [ ]T8 [ ]T9 [ ]T10 [ ]T11 [ ]T12 [ ]T6-7 [ ]T7-8 [ ]T8-9 [ ]T9-10 [ ]T10-11 [ ]T11-12 [ ]T12-L1

LUMBAR———————— [ ] Left [ ] Right [✓] Bilateral
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [✓] MBB (Facet Nerve Injection)***
[ ] Sympathetic [ ] Radiofrequency [ ] Discography [ ] Caudal/Catheter Directed [ ] Sacroiliac Joint
LEVELS: [ ]L1 [ ]L2 [ ]L3 [ ]L4 [ ]L5 [ ]S1 [ ]S2 [ ]L1-2 [ ]L2-3 [ ]L3-4 [ ]L4-5 [✓]L5-S1
[ ] OTHER: [ ] †TSCS [ ]
[✓] UNDER FLUOROSCOPY †TSCS Trial Spinal Cord Stimulator
*SNRB=Selective Nerve Root Block **TFESI=Transforaminal Epidural Steroid Injection ***MBB=Medial Branch Block

INTRAOPERATIVE ORERS: Oxygen at 2-4 L/NC **CONSCIOUS SEDATION** [✓] Versed 1 mg [✓] Alfentanil 500 mcg
[ ] Propofol ___ mgs [ ] Fentanyl ___ mcg [ ] Romazicon ___ mg
Noted 5/8/17 @ 1254- McRN
For Radiofrequency Treatment: See RF Neurotomy Procedural Notes Form. Medications drawn up as ordered on MD preference cards.

	PACU ORDERS
	1. Check vitals every 5 minutes x 2 then up to chair/dangle with 1 set of vitals. Record post-procedure temperature readings on patients who received Stellate Ganglion and Sympathetic injection procedures. If local infiltrate and no sedation performed, take vital signs x1. Discharge when patient stable.
Noted	2. For Stellate Ganglion and Sympathetic injections, record temperature on appropriate bilateral extremities.
[illegible]	3. Oxygen nasal prongs or mask to as needed to maintain pre-op oxygenation level.
	4. Ice chips or liquids as tolerated. Ondansetron 4mg IVP/IM for nausea or vomiting prn.
5/8/17	5. Do blood sugar testing if pt. received treatment for blood sugar level.
	6. Remove IV catheter just before discharge.
	7. Resume all prior medications. [ ] NA
1207	8. Resume all anticoagulants on next scheduled dose after the procedure. [ ] NA
	9. Provide and review written copy of post procedure instructions with patient & family members.
	10. Pt may be discharged in ½ hr if post-reversal agent. [ ] yes [ ] no
	11. Other orders:

PHYSICIAN'S SIGNATURE: ________

VALLEY VIEW SURGERY CENTER
Standing Orders - K. Travnicek, M.D.

Patient Label
NAME: SEKERA, JOYCE P JS555
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: May 8, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED DIAGNOSTIC FACET JOINT MEDIAL BRANCH BLOCKS BILATERAL L3-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a stylefied spinal needle was inserted percutaneously and directed to the lateral base of the superior articulating process at corresponding to each nerve to be anesthetized. Each site was then injected with contrast to confirm location and to rule out intravascular injection. Each site was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Alfentanil Midazolam
CONTRAST: Omnipaque
INJECTATE (each site): Lidocaine (pf) 2% final concentration 0.5 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

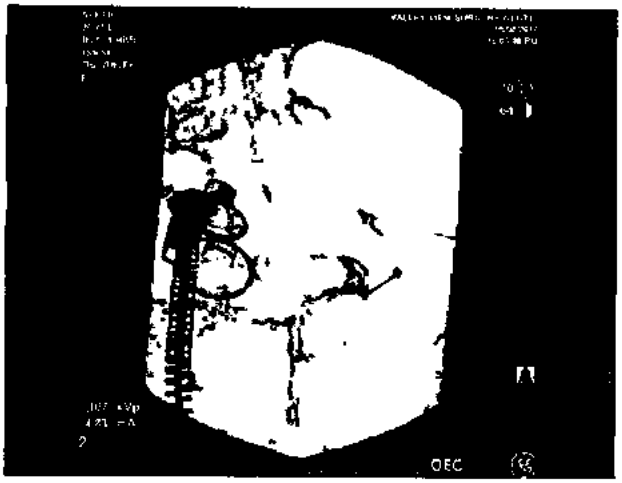
POST-PROCEDURE PAIN: 100% reduction in usual pain.

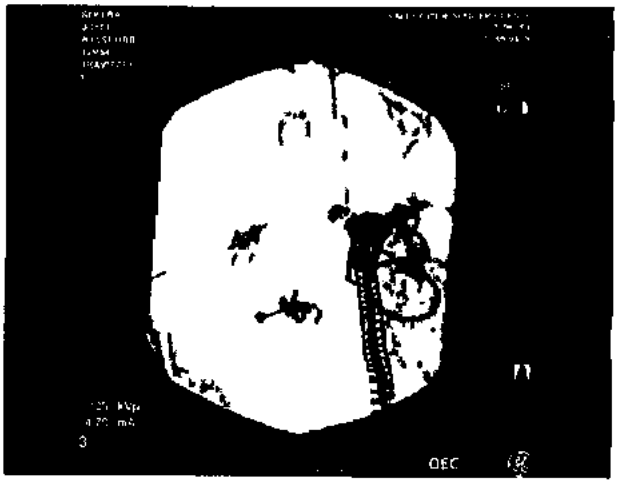
Electronically signed by KATHERINE TRAVNICEK Date: 5/08/2017 Time: 13:38:07

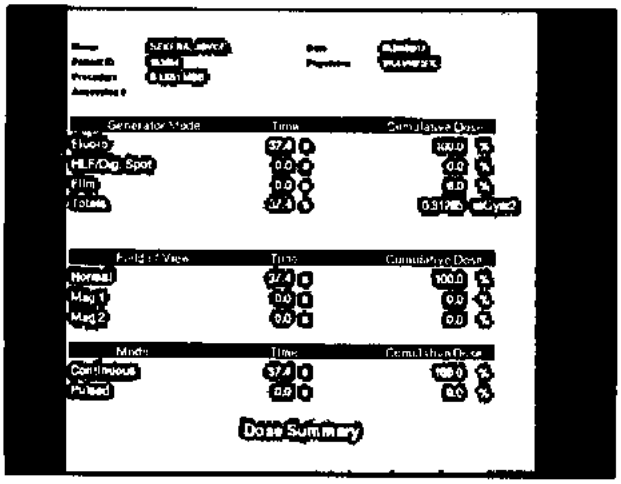
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

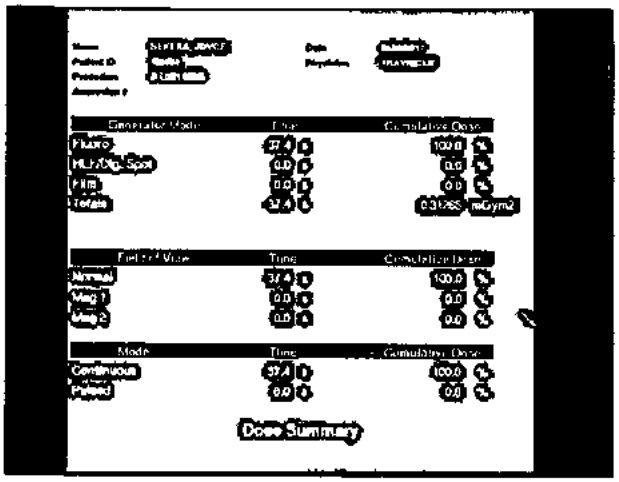
JS556

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F









NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Valley View Surgery Center

Fluoroscopic Images

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Patient label

NAME: SEKERA, JOYCE P JS557
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure.	Greet patient, check two patient identifiers and verify operative site, allergies and other pertinent information. Safety straps applied, patient positioned appropriately with good body alignment and pressure points padded.	Operative site, correct patient and permanent history verified. Allergies noted Patient encouraged to ask questions about care in the operating room. Proper body alignment and safety straps used. Electrical equipment checked and ensured to be in safe condition.	Initials:

ALLERGIES: ☑ NKA ☐ See Front of Chart

TX # 1 Time in TX: 1250 "TIMEOUT" by M @ 1253 w/MD and all listed staff present

Time PROCEDURE BEGAN: 1255 Time PROCEDURE ENDED: 1301 TIME PT LEAVING TX 1305

If STAGED in room or change in position/different site area:

"TIMEOUT" by ____ @ ____ w/MD and all listed staff present

Time PROCEDURE BEGAN: ____ Time PROCEDURE ENDED: ____ TIME PT LEAVING TX ____

PAIN MANAGEMENT PERSONNEL

DR. PERFORMING PROCEDURE: Dr. K. TRAVNICEK ANESTHESIA: ☑ IVCS ☐ MAC ☑ LOCAL INFILTRATE ☐ GENERAL ☐ OTHER

☐ ANESTHESIOLOGIST ☑ IVCS NURSE U. Cardenas RN CIRCULATOR N. Buettner RN

MED NURSE M. Silverstein RN ☐ N/A SCRUB T. Swift CST X-RAY M. Pessalagne OTHER ____

MEDICATIONS GIVEN BY PHYSICIAN DURING THE PROCEDURE:

☐ 1% Lidocaine MPF ☐ 0.5% Bupivacaine MPF ☐ 0.9% Normal Saline ☑ Omnipaque 300 mg plain

☑ 2% Lidocaine MPF ☐ Dexamethasone ☐ Myoblock ____ Units ☐ Omnipaque 300 mg Added ☐ Ancef ____ mg

☐ 4% Lidocaine MPF ☐ Methylprednisolone ☐ Pump medication verified with attending MD

(The dose and route of the medications given are noted on the procedural report of the physician performing the procedure.)

PRE-OP DIAGNOSIS: Lumbar Spondylosis

PROCEDURE: [ ] Cervical [ ] Thoracic [✓] Lumbar [ ] Caudal [ ] Hip [ ] Knee [ ] Shoulder (Number multiple procedures in sequence)

[ ] Discography

[ ] Epidural Steroid Injection

[ ] Facets: [ ] Right [ ] Left [ ] Bilateral

[ ] Intercostal Nerve Block: [ ] Right [ ] Left [ ] Bilateral

[✓] Medial Branch Block: [ ] Right [ ] Left [✓] Bilateral

[ ] Occipital, Greater/Lesser: [ ] Right [ ] Left [ ] Bilateral

[ ] Radiofrequency: [ ] Right [ ] Left [ ] Bilateral See RF Neurotomy Procedural Notes Form

[ ] Sacroiliac Joint: [ ] Right [ ] Left [ ] Bilateral

[ ] Selective Nerve Root Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Stellate Ganglion: [ ] Right [ ] Left [ ] Bilateral

[ ] Sympathetic Block, Lumbar [ ] Right [ ] Left

[ ] Transforaminal epidural steroid injection: [ ] Right [ ] Left [ ] Bilateral

[ ] Trial Spinal Cord Stimulator [ ] Trial Pain Pump [ ] Other ____

Prep to operative site: ☐ Duraprep ☑ Chloraprep: ☐ Tinted ☑ Clear By: T. Swift CST

Positioning: ☐ Supine ☑ Prone ☐ Lateral ☐ Arms tucked ☑ Pillows for positioning

☐ Padded toboggans used for arm protection ☑ Safety strap on x 3

POST OP DIAGNOSIS ☑ SAME ☐ Other ____ ☐ Pain log given

Notes: ____

☑ Radiation Skin Status - Pre Radiation ☑ All Clear Post Radiation ☑ All Clear

CIRCULATOR SIGNATURE N. Buettner RN

Valley View Surgery Center

Pain Management OR Record

Dr. K. Travnicek

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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JS558

Pre-OP Vitals BP 94/77 HR 53 RR 18 O_2 Sat 96 % ☐ Room air ☐ Oxygen @ ___ L/min Temperature 97 F

ALLERGIES ☑ NKA ☐ See Front of Chart

Legend: v = Systolic BP, ^ = Diastolic BP, • = Pulse	Time	1250	1264	1265	1300
	220				
	210				
	200				
	190				
	180	v			
	170				
	160				
	150				
O_2 Appliance: ☑ Cannula ☐ Mask	140				
O_2 Liter Flow @ 3 L/min	130			v	v
ECG: ☐ NSR	120				
☑ Sinus Bradycardia	110				
☐ Sinus Tachycardia	100				
☐ Other:	90				
IV Site: ☑ Right arm	80				
☐ Left arm	70	^		^	^
☐ Other:	60				
Condition: ☑ Patent	50	•	•	•	•
☐ Other:	40				
Solution: ☑ Saline Lock	30				
☐ Isolyte ☐ 0.9% NaCl	SaO_2	100	100	99	100
☐ Other:	RR	18	18	16	16
Acceptable range 35-45mmHg	$ETCO_2$	36	37	39	37
ETCO2 Waveform present ✓		√	√	√	√
CONSCIOUS SEDATION SCALE					
Respirations: 0. Appear Adequate 1. Impaired exchange 2. Dyspnea/Obstructed		0	0	0	0
Level of Consciousness: 0 Alert or awakening 1 Follows commands / Intermittent arousal 2. Unresponsive		0	0	1	1
Vital Signs: 1. Increase (+ 21% of pre-anesthetic level) 2. Within acceptable limits 3 Decrease (+ 21% of pre-anesthetic level)		2	2	2	2
Physical / Emotional Affect: 0. Resistive / Intense / Anxious / Uneasy 1. Tempered or intermittent response/ Calm / Tolerant 2. No response		1	1	1	1
Total Sedation scale (Optimal 3-5)		3	3	4	4
MEDICATIONS					
☑ Versed IV mg			1		
☐ Fentanyl IV mcg					
☑ Alfentanil IV mcg			500		
☐ Propofol IV mg					
☐ Romazicon IV mg					
☐ Narcan IV mg					
☑ Cefazolin IV mg					
☐ Other:					

IVCS RN Printed Name: M. Cardenas **Signature:** M. Cardenas, M **Initials** MC

Antibiotic: ☒ NA _____ **completed at** _____ **by** _____

☑ Patient tolerated procedure well and was transferred to PACU in apparent good condition.

☑ Report given by IVCS/circulating nurse and care handed over to **PACU Nurse** D. Gasper Rn

VALLEY VIEW SURGERY CENTER
IVCS by RN

Patient Label

JS559

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

M:\FORMS\Clinical forms\017A IVCS by RN.doc rev 100413 fd

Nursing Diagnosis	Outcome/Goal	Plan	Interventions/Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure	Ensure immediate , on-site availability of back-up personnel for airway management, resuscitative emergency intubation and emergency equipment	Emergency equipment will be present, working properly and immediately available in the room where the procedure(s) are performed Nursing assessment conducted by IVCS nurse including pertinent medical history, verification of allergies, confirmation of NPO status	
Potential decrease in blood pressure, heart rate, peripheral resistance and oxygen saturation, especially during administration of sedation agent(s)	Patient vital signs will remain within patient's normal limits as evident by the utilization of monitoring equipment peri-operatively	Explain monitoring equipment and ECG pads to patient	ECG electrodes, blood pressure cuff and pulse oximeter applied prior to procedure Vital signs will be monitored continually throughout the procedure at a minimum before the start of procedure, one minute after administration of medication(s) given, and at least every five minutes thereafter until procedure is completed	
Potential for anxiety and pain related to therapeutic and/or diagnostic procedures	Patient will be able to tolerate diagnostic and/or therapeutic procedures with reduced anxiety and discomfort. Patient's LOC will be mildly depressed with an altered perception to pain, but will retain the ability to respond appropriately to verbal and/or tactile stimulation	Sedation agent(s) will be administered per physician's orders	Pts LOC will be assessed at regular intervals, verbal reassurance will be given to divert patient's attention and assist in reducing anxiety	Initials: MC

Date: 5/8/17 Monitors On ☑ Alarms Set ☐ Allergies: ______ ☑ NKA ☐ See Front of Chart

Procedure: Bilateral L5-S1 MBB

PreOp: B/P 144/77 Pulse 53 RR 18 SaO_2 96 % ☑ RA ☐ @ ___ L/min Temp: 97.7 Pain Level: 4 Initials ___

ADMIT TIME	BP	PULSE	RESP	O2 SAT		TEMP	PAIN LEVEL
				%	NC/RA		
1307	147/69	48	15	99	NC	97.4	0
1312	116/74	55	15	99	NC	–	0
1317	144/74	57	15	96	RA	–	3-4

POST ANESTHESIA ASSESSMENT/RECOVERY SCORE			ADM	DISCHARGE
Purposeful movement of all extremities / Moves two extremities / No movement of extremities	=2 / =1 / =0	Activity	1	2
Breath deeply and cough freely / Limited and/or impaired breathing / Apnea	=2 / =1 / =0	Resp	2	2
BP stable or improved over PreOp readings. Pt. asymptomatic / Pt. outside of acceptable range based on PreOp readings. / Unstable Hypotension or Hypertension	= 2 / =1 / = 0	Circ	2	2
Alert, fully awake, responding appropriately / Responds to name and/or verbal stimuli / Unresponsive	=2 / =1 / =0	LOC	1	2
Normal skin color/SpO_2 > 92% on room air / Pale, Supplemental O_2 for SpO_2 > 90% / SpO_2 < 92% with O_2 supplementation	= 2 / =1 / =0	Color	1	2
Totals:				
DISCHARGE CRITERIA: SCORE 10 or pre anesthesia			7	10

TIME	MEDICATION/DOSE/ROUTE/SITE FOR IM OR SQ INJECTIONS	PAIN LEVEL	INITIALS

NURSES NOTES: (Must make comments for * outcome discharge answers)

1317 – Dr's assistance @ bedside, had pt stand up / bend to assess pain. Pt rate pain @ 3-4/10.
1325 – Dr's assistance had pt stand up again + bend to reassess pain, pt now states pain @ 0/10.
Pt tolerating juice / crackers.
D. Dasparren

☐ Pt. given pain log and understands instructions as noted by pt.'s verbalization. ☐ NA

☐ Time: ______ Pt. up in wheelchair. Medically discharged. Waiting for ride.

Signature: D. Dasparren Initials: DG

Signature: ______ Initials: ______

DISCHARGE

Pt. tolerated procedure without apparent injury: ☑ Yes ☐ No*

Safety maintained: ☐ Yes ☐ No*

LOC: ☐ Alert ☑ Oriented same as PreOp level ☐ Sedated* ☐

☐ Nausea/Vomiting ☑ NA ☐ Minimal/Not treated ☐ Treated

Intake: PO 100 mls IV 0 mls

Discharge Criteria Met: ☑ Yes ☐ No*

IV catheter removed / catheter intact ☑ Yes ☐ No*

S/S of complications due to IV: ☑ No ☐ Yes*

Copy of post op instructions given to pt./other: ☑ Yes ☐ No*

Prescription given: ☐ NA ☐ Yes If yes, instructed pt to take medication as written on prescription ☐ Yes ☐ No

Instructed pt. to resume medications as instructed / ordered by MD. ☐ Yes ☐ No

Pt./other states understanding of all instructions: ☑ Yes ☐ No*

Mobility unchanged from Pre Op level: ☑ Yes ☐ No*

Discharged via w/c to responsible adult: ☑ Yes ☐ No*

Discharge Pain Level: ~~3-4~~ 0 Discharge Time: 1338

VALLEY VIEW SURGERY CENTER

POST PROCEDURE RECORD

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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JS561

POST-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Altered airway Function Post-anesthesia	• Observe & maintain or support airway as needed • O_2 on arrival / PRN • Monitor SaO_2 • Appropriate position	Patient airway with maximum respiratory compliance as evidenced by adequate O_2 exchange, tissue perfusion & visible hemodynamics. Clear airway without assist	Goal is obtained: ☑ Yes ☐ No Comments:
Altered hemodynamics potential for hypovolemia	• Monitor EDG for arrhythmia • Note/intervene for B/P +/- 50% of pre-op reading • Observe surgical site for bleeding	Stable hemodynamics	Goal is obtained: ☑ Yes ☐ No Comments:
Altered level of consciousness	• Stimulate adult patient PRN • Do not stimulate pediatric patient if airway & hemodynamics are stable • Orient patient to surroundings • Observe for altered L.O.C.	Patient will be arousable, oriented and as alert as possible prior to discharge	Goal is obtained: ☑ Yes ☐ No Comments:
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety. Able to verbalize pos-op instructions (i.e. diet, wound care, pain control & activity)	Goal is obtained: ☑ Yes ☐ No Comments:
Potential injury	• Utilize side rails (peds PRN) • Place bed in low position • Secure IV's and assess for patency • Ensure correct physiological positioning	No injury in PACU	Goal is obtained: ☑ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Relief of pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments:
Nausea & Vomiting ☑ N/A	• Recognize nausea • Medicate as ordered • Teach relaxation techniques • Position for comfort & to prevent aspiration	Relief of nausea verbalized	Goal is obtained: ☐ Yes ☐ No Comments:

Initials of Nurse _____

Nurses Notes Continued as needed:

If EKG strip affixed to record, complete the following:

Time _____ am/pm

Dr. _____ notified @ _____ am/pm

Per MD's order: ☐ No treatment
☐ Treatment: _____

Signature of RN: _____ Time: _____ am/pm

Debbie

Date: 050817 Time Admitted: 1115 **PRE-OP CHECKLIST** 702 610-6410

Pt. identified by ☑ full name ☑ date of birth by ____ From: ☐ Home ☐ Other ____ Via: ☑ Walking ☐ Wheelchair ☐ Carried

Planned Procedure: Bilateral L5-S1 MBB NPO since: 050817 AM Meds: ☐ Yes ☑ No

Responsible Adult taking pt. home: mother Driver: Carole ☐ Same ☐ Waiting ☑ Call at: ____

MEDICAL HISTORY: ☐ Asthma ☐ Ulcers ☐ Hiatal Hernia ☐ TMJ ☐ SOB ☑ Diabetes ☐ MVP ☐ Stroke ☐ Sleep Apnea ☐ Hepatitis ☐ Hypertension ☑ Smoker ☑ Chest Pain/Previous MI (Date____) ☐ Palpitations ☐ Seizures ☑ Back/Neck Problems ☐ Thyroid Problems ☐ AIDS/HIV Positive ☐ Street Drugs ☑ Arthritis ☑ Osteoporosis ☐ Other/Notes: ____

SURGICAL HISTORY: ☐ Tonsils/Adenoids ☐ Gallbladder ☐ Hysterectomy ☐ CABG ☐ Hernia ☐ Appendix ☐ Back ☑ Hip ☐ Sinus/Nasal ☐ Biopsy ____ ☐ D&C ☑ Laparoscopy ☐ Metal Implants ☐ Pacemaker/ICD ☐ Foot ☐ Cervical ☐ Knee ☐ Eye Surgery ☐ Other/Notes: ____

Medication list: See Pre-Anesthesia Record and Patient Home Medication List

VITAL SIGNS: Weight 95.5 kg Height 5'10 **ALLERGIES:** ☑ NKA

SAO_2 94 % ☑ RA @ ____ L/min Temp 96.7 Pulse 73 Resp 18

BP 144/77 ☑ R ☐ L arm Extremity temp: R ____ L ____ ☑ NA ☐ See Front of Chart

SYSTEMS ASSESSMENT ☑ or ☑ = Fall Risk If ≥4 ☑ or ☑ checked, ☑ Fall Risk Band applied

Respiratory:

Respiration: ☑ unlabored ☐ labored ☐ other ____

Breath Sounds: ☑ audible ☑ clear ☐ other ____

Cough: ☑ absent ☐ non-productive ☐ productive ☐ other ____

Cardiovascular:

Heart tones: ☑ regular ☐ irregular ☐ other ____

Color: ☑ pink ☐ cyanotic ☐ other ____

Neuro Sensory:

☑ alert ☑ oriented ☑ confused ☐ other ____

Psychosocial: ☑ calm ☐ anxious ☐ crying ☐ angry ☐ other ____

Skin: ☑ normal ☐ pink ☐ cyanotic

☑ warm ☐ cool ☐ dry ☐ diaphoretic ☐ other ____

GI / GU: ☑ normal ☐ incontinent ☐ other ____

Activity: ☑ full ☐ ROM ☑ uses assistive device ☑ Fall within 3 mo ☐ other

***Pain Intensity Level:** 4 Location: low back Pain Quality: constant

CHECKLIST	Yes	No	NA
Consent	✓		
H&P	✓		
H&P (Podiatry)			
CXR			
EKG			
CBC			
Coag.			
Urine			
Lytes/Chem panel			
Preg Urine/Serum			
Hepatitis Screen			
HIV			
Bowel prep finished			
Surgical Site Clipped			
Medical Clearance			
TEDs/SCDs			

TESTING ON UNIT	RESULTS	N/A
Urine Pregnancy	65 / 5 Cmp	
AccuChek		
☑ FBS ☐ RBS	88	
Normal range FBS 70 – 200 mg/dL		

PREMEDICATIONS:

Times	Medication / Dose	By

Pre-Op teaching done ☑ Yes ☐ No

Discharge inst. given ☑ Yes ☐ No

Patient ride confirmed ☑ Yes ☐ No

Valuables w/	Patient	Family	None
Dentures	✓		
Glasses/Contacts			✓
Hearing aids			✓
Clothes	✓		
Jewelry/ Body Jewelry	*See back		✓

Procedure or surgery site:

☑ Confirmed w/pt: ☐ right ☐ left ☑ bilateral ☐ NA

☐ Marked by MD

IV started in holding: ☑ Yes ☐ No Attempts X2 Initial (2)

Flush: ☑ 3 mls NS ☐ IV ____ ☐ ____ mls

Site: ☐ R ☐ L ☑ Superior Dorsal ☐ Anticubital vein

☐ Other: ____ Gauge ☐ 18 ☐ 20 ☑ 22 ☐ 24 Exp: 0/w

ID band applied by: ____

☐ Pt. tolerated tx. ☐ Other ____

SIGNATURES (Initial)

R. Genao (12)

( )

To OR via: ☐ gurney ☐ side rails up ☐ bed ☐ low ☐ carried ☐ walk in

Valley View Surgery Center

PRE-OP CHECKLIST

M:\FORMS\Clinical forms\PRE OP CHECKLIST rev120716pp

Patient Label

JS563

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

PRE-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety	Goal is obtained: Yes No Comments:
Potential Injury	• Utilize side rails (pads PRN) • Place bed in low position/chair locked • Secure IVs & assess for patency • Ensure correct physiological positioning	No injury in Pre-Op	Goal is obtained: ✓Yes No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Pain verbalized using pain scale	Goal is obtained: ✓Yes No Comments:

Pre-Op Nurse Initials: IB

NURSE'S NOTES

*Confirmed/witnessed with pt.: Jewelry secured in closed plastic bag. Bag placed in pt.'s belonging bag.

Nurse's Initials:

TIME	
1150	Patient was diagnosed of Diabetes 2 days ago. Does not take medication or exam it yet - IB

Reference: AAAHC Institute for Quality Improvement, *Patient Safety Toolkit: Ambulatory Surgery and Preventing Falls*, 07/22/13

JS564

Height / Estatura	5'6"	Actual Weight / Peso	205 lb.

Allergies: / Alergias: nkda

1. Have you taken any of the following medications:
Ha tomado los medicamentos listados:

Aspirin: Yes, date last taken / Aspirina: Si, ultima fecha tomada		☐ Yes	☑ No
Plavix: Yes, date last taken / Si, ultima fecha tomado		☐ Yes	☑ No
Coumadin: Yes, date last taken / Si, ultima fecha tomado		☐ Yes	☑ No
Anti-Inflammatory: Yes, date last taken / Anti-Inflamatorios Si, ultima fecha tomado		☐ Yes	☑ No

2. For female patients only:
Date of last menstrual period_____ ☑ N/A
Para mujeres solamente: fecha de su ultima menstruación_____

3. List all previous surgeries (and when)
Lista de todas cirugías previas (con fechas)

4. Do you symptoms of tuberculosis
Ha sido diagnosticado con Tuberculosis-

-Productive cough / -Tos productiva	☐ Yes ☑ No	-Weakness, Fatigue / -Fatiga, debilidad	☑ Yes ☐ No
-Bloody sputum / -Esputo con sangre	☐ Yes ☑ No	-Night sweats / -Sudores nocturnos	☐ Yes ☑ No
-Unexplained weight loss / -Perdida de peso inexplicable	☐ Yes ☑ No	-Fever / -Fiebre	☑ Yes ☐ No

HISTORY / HISTORIAL	Yes / Si	No
5. Have or are you taking "street drugs" **If yes, last date**_____ Ha o está tomando drogas ilegales En caso que si, fecha ultima: _____	☐	☑
6. Do you use Medical Marijuana? **If yes, last date:**_____ Utilizas la marihuana medicinal En caso que si, fecha ultima:_____	☐	☑
7. Have you had recent weight change? (Significant amount) Has tenido cambio significante en peso		

HISTORY / HISTORIAL	Yes / Si	No
8. Do you smoke? **If yes, cigarettes per day:** 4 ¿Fuma? En caso que si, cuantos cigarrillos per dia ___	☑	☐
9. Do you have caps, false teeth, bridge, partials or contact lenses? ¿Tiene dientes falsos, tapas, dentaduras/Puente parsial o lentes de contacto	☑	☐
10. Do you drink alcoholic beverages? **If Yes, how much** _____, **last time**_____ ¿Consume bebidas alcolicas? En caso que si, cantidad _____	☐	☑
11. Have you ever experienced any reaction to rubber or latex products? Alguna vez ha experimentado una reacción a los productos de goma o látex **If yes, please describe** En caso que si, por favor describa	☐	☑
12. Glaucoma Glaucoma	☐	☑
13. TMJ (dysfunction of temporomandibular joint) TMJ (disfunción de la articulación temporomadibular)	☐	☑
14. Stiff neck Cuello tieso	☐	☑
15. Shortness of breath Dificultad para respirar	☐	☑
16. Asthma Asma	☐	☑
17. Heart attack Ataque de Corazón	☐	☑
18. Chest pain; angina Dolor de pecho	☐	☑
19. Palpitations Palpitaciones	☐	☑
20. High blood pressure Alta presión	☐	☑
21. Implanted pacemaker/defibrillator Marcapasos / desfibrilador	☐	☑

CONTINUE ON BACK
CONTINUAR EN LA PARTE POSTERIOR

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17
AGE: 61
SEX: F

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)

M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

JS565

HISTORY HISTORIAL	Yes Si	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☑
23. **Hepatitis** Hepatitis **If Yes /** En caso que si **Type** ☐ A ☐ B ☐ C	☐	☑
24. **Hiatal Hernia** Hernia Hiatal	☐	☑
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** _____ ¿En caso afirmativo, cuando? _____	☑	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☑
27. **Ulcers** Ulceras	☐	☑
28. **Stroke** Derrame Cerebral	☐	☑
29. **Seizures** Convulsiones	☐	☑
30. **Parkinson disease** Enfermedad de Parkinsons	☐	☑
31. **Blackouts** Desmayos	☐	☑
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☑
33. **Back / Neck Problems** Problemas de cuello / espalda	☑	☐
34. **Osteoporosis** Osteoporosis	☐	☑
35. **Muscle Diseases** Enfermedad Muscular	☑	☐
36. **Arthritis** Artritis	☐	☑
37. **Diabetes** Diabetes	☑	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☑
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☑
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☑
41. **Blood Transfusion** Transfusión de sangre	☐	☑
42. **Kidney Disease** Enfermedad de Riñones	☐	☑
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que Si, fecha de ultimo tratamiento?	☐	☑

HISTORY HISTORIAL	Yes Si	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☑
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☑
46. **Metal Implants** Inplantes Metálicos	☐	☑
47. **Cancer** **If Yes, Where**_____ Cancer En caso que Si, en donde_____	☐	☑
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☑
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☑
50. **Draining wound** Herida abierta	☐	☑
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☑
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☑

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

_____

Signature (Patient/ or Person filling out form)
(If other than patient; relationship :_____)

_____

Firma (Paciente/representante)
(relación al paciente: _____

5/8/17
Date/Fecha

_____ 0800
Signature of Pre Op Nurse — Date

☐ = Fall risk

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

JS566

Valley View Surgery Center

PATIENT HOME MEDICATION LIST (As Provided by Patient)

Please fill in highlighted areas only and bring form back to VVSC before or on the day of your procedure.

☐ No Known Allergies

ALLERGIES AND THEIR REACTIONS:

List all medications taken over the past 6 months (include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment.)

Medication Name	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: 3/9/17 Last Taken (Date/Time)	Date of Visit: 5/8/17 Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)	Date of Visit: Last Taken (Date/Time)
None							

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt Copy in MR
				**	**	**	**
				*☐CMI Unk	*☐CMI Unk	*☐CMI Unk	*☐CMI Unk
				☐ ¥	☐ ¥	☐ ¥	☐ ¥
				☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC	☐Copy of med list given to pt. on DC

**Pre-Op Nurse Signature

* Complete Medication Information Unknown by pt. = CMI Unk

¥ Is PACU Nurse Signature

** ☒Check box if pt./cg instructed on medication use, common side effect, and aftercare upon discharge.

******** Contact your prescribing physician for questions regarding any medications listed on this page ********

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

PATIENT LABEL

PATIENT LABEL

rev 010917 PP.doc

JS597

594

VVSC Surgical/Procedural Safety Checklist

Note: Patient is patient himself/herself or legal representative or surrogate	Pre-Op	OR	PACU
1. Ensure a clean and sanitary environment for each patient.	✓	✓	✓
2. Patient identified as per VVSC policy & ID Band is on patient	✓	✓	✓
3. Allergies/ adverse reactions verified and stated on front of chart	✓	✓	✓
4. Surgery/Procedure Consent: Operative Procedure & site verified with patient	✓	✓	
a. Patient's Signature	✓	✓	
b. Witness Signature	✓	✓	
5. Anesthesia Consent:	✓	✓	
a. Patient's Signature	✓	✓	
b. Anesthesia Provider (Anesthesiologist or MD performing procedure) Signature	✓	✓	
6. H & P – to include heart and lung (Noted on Pre-Op checklist form)	✓	✓	
7. Pre-Op MD Orders	✓	✓	
a. As ordered, pre-op test(s): ☐ Completed, results reviewed and placed in chart ☐ Not present, action taken (See pre-op checklist nurse's note) ☑ N/A	✓	✓	
b. Standing Orders to draw blood sugar and /or urine pregnancy test ☑ N/A	✓		
c. Actions if blood sugar is out of range. Noted on back of Pre-Op Checklist and in blood sugar result log ☐ N/A	✓		
d. Antibiotic as ordered: ☐ Initiated ☐ Completed ☑ N/A	✓	✓	
e. *Any special equipment, devices, implants ☐ Yes ☑ N/A	✓	✓	
8. Procedure Site: MD marked Operative site ☐ Yes ☑ N/A	✓		
9. Pre-Op Anesthesia/Nurse Assessment Form / Medication List	✓		
a. Patient Signature	✓		
b. Nurse Signature	✓		
c. Medication list has dosage, frequency, date last taken. If pt. doesn't know, document	✓		
Any G-Code documented? ☐ No ☐ Yes List G-Code_____ See back of sheet for	✓		
10. IntraOp or Intra Treatment: Ensure a clean and sanitary environment for each patient	✓		
11. Intra Operative briefing before procedure started: *Time-Out* performed per policy, allergy status and other concerns discussed- *difficult airway or aspiration risk or aspiration risk, risk of blood loss if applicable			
12. *Procedure site is marked and visible ☐ N/A			
13. *Relevant images properly labeled and displayed ☐ N/A			
14. *De-briefing after completion of procedure			
a. Name of procedure performed			
b. Sponge, sharp count performed ☑ N/A			
c. Specimens identified and labeled ☑ N/A			
d. *Any equipment problems to be addressed ☑ N/A			
e. *Key concerns for recovery and management of this patient ☑ N/A			

JS568

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

	Pre-	OR	PACU
15. Sterilization Documentation completed/initialed			
16. O. R. Record Complete with out of OR time			
# 10 to #16 completed by			
Any G-Codes occurrences? ☑ No ☐ Yes List G-Code_____ **See below for references**			
17. Ensure a clean and sanitary environment for each patient			DR
18. Admit time to PACU			DR
19. Post Op Orders Noted			DR
20. Signature of Discharging MD for anesthesia recovery Discharge time on PACU record			DR
21. Discharge time to home or transfer to hospital noted ☑ Yes			DR
22. Copy of VVSC's prescriptions ☐ Yes ☑ N/A			DR
23. Name of responsible adult pt. discharged to noted on discharge instructions			DR
24. Phone number of the physician doing surgery or procedure on discharge instructions			DR
Any G-Codes occurrences? ☑ No ☐ Yes List G-Code_____ **See below for references**			DR
Nurse Name: **Printed** K Genaw	Signature: Kenow	/ Initials:	DR
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed** D. Grasman	Signature: D. Grasman	/ Initials: DG	
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
RN Co-sign for LPN: **Printed**	Signature:	/ Initials:	

ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE First and last name initials signify the nurse has completed the listed responsibility. "O" with initials next to it signifies the nurse assessed the responsibility and completion is needed. *Revisions/Additions to this form adopted from AORN Comprehensive Surgical Checklist that incorporated WHO, Joint Commission-Universal Protocol (JC) 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	**G8908** Patient documented to have received a burn prior to discharge
Patient Fall	**G8910** Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	**G8912** Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	**G8914** Patient documented to have experienced hospital transfer/admission
Prophylactic IV Antibiotic Timing	**G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
	G8917 Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.

I consent to the admission to Valley View Surgery Center (VVSC) for my treatment(s) and authorize VVSC, staff, and doctor(s) to provide care. I authorize and direct **DR. TRAVNICEK** to perform the following treatment(s) or any other treatment deemed necessary at the discretion of the physician:

BILATERAL LUMBAR FIVE-SACRAL ONE MEDIAL BRANCH BLOCKS WITH THE USE OF FLUOROSCOPIC GUIDANCE

Physicians providing services at VVSC are not agents or employees of VVSC.

I understand I have the right to be informed. My physician has explained the treatment(s) necessary to treat my condition, purpose of the treatment and its associated anticipated benefits, including but not limited material risks, and alternative methods of treatment and its associated anticipated benefits, including but not limited material risks. No guarantee has been given as to the results that may be obtained. I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results. I have the right to be informed of the likelihood of success and the problem(s) associated with recuperation and the possible results of non-treatment. I have the right to request/consent to or to refuse any proposed treatment at any time prior to its performance.

I have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation/procedure. I have the right to be informed if any professional relationship to another health care provider or institution that may suggest a conflict of interest exists.

If applicable, I authorize the administration of anesthesia from an anesthesia provider as may be deemed necessary for the treatment.

My signature below authorizes the pathologist to use his/her discretion in disposing of any tissue removed from my person during the treatment(s) described above. I authorize x-rays, photographs, or videotaping for diagnostic or medical education purposes including utilization of medical residents, students, and/or manufacturing representatives.

I authorize to the drawing of a blood sample from my body in the event that an employee or physician of the surgery center has an accidental puncture or mucous membrane (eye, mouth, etc) exposure to my blood or body fluids. The blood samples will be tested for HIV and Hepatitis. No results of any tests done on my blood will be released or shown to any unauthorized person without my written consent.

My signature on this form indicates that I have read and understand the information provided on this form, that the treatment(s) described above has been adequately explained to me by my physician, that I have had the opportunity to ask questions, that I received the information I desire concerning the treatment, and that I consent and authorize to the performance of the treatment(s) upon myself.

I understand and agree that I am solely responsible for maintaining the privacy of my protected health information in the paperwork I received.

I have not eaten or drank since (Date& Time) 050817 4am ☑Fluid, _____ (am't), ☑Solid 050817 7pm
I have a responsible adult to drive me home.

☒ Joyce Sekera — 050817 — 1150
Patient's Signature or Patient's Representative or Surrogate — Date — Time
Relationship to Patient: ☑Self ☐Other

Karen — 050817 — 1150
Signature of person witnessing the patient's or patient's legal representative signature — Date — Time

☑ Verified consent — M — Initials of circulator

< SEKERA, JOYCE >

Valley View Surgery Center

Treatment Consent/Authorization

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Ad NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS570

Patient Consent for Anesthesia at Valley View Surgery Center

I understand:

I will need anesthesia services for the surgery/procedure to be done today.

- And the amount of anesthesia to be used will depend upon the procedure(s) and my physical condition. Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical/surgical procedure.
- During the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
- Although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are a part of the risks I must consider in deciding to have a procedure. Some of the unusual risks and complications of anesthesia may include but are not limited to allergic or adverse reactions, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and of redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/by others, seizures, sore throat, and death.
- A detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to inform me. No guarantees have been made by anyone regarding the anesthesia services which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS:

Patient Initials	
_____	☐ **General Anesthesia:** 1. Mask Anesthesia- Gases are passed through a mask which covers the nose and mouth or 2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth or 3. Laryngeal/Mask Anesthesia- Gases are passed through a mask placed behind the tongue which covers the larynx (voice box) or 4. Deep sedation.
_____	☐ **Regional Anesthesia** 1. Nerve block-Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.
_____	☐ **Monitored Anesthesia Care (MAC), Total Intravenous Anesthesia (TIVA)** - The anesthesiologist monitors blood pressure, oxygenation, pulse, and mental state and supplements sedation and analgesia as appropriate.
_____	☐ **Local Anesthesia** 1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedure site. 2. Topical Anesthesia- Surface anesthesia is produce by direct application of anesthetizing agents on skin or membrane.
_____	☑ **Conscious Sedation by RN** - Involves the use of intravenous medication administered by licensed registered nurses under the direct supervision of the physician performing the surgery/procedure.

DNR ORDERS: I understand that DNR (do not resuscitate) orders will be suspended while I am in the procedure and until I completely recover from the effects of anesthesia.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to the acceptance of anesthesia might be no anesthesia for the procedure.

X _____ 050817 1130

Patient's Signature or Patient's Legal Representative — Date — Time

_____ 050817 1130

Signature of person witnessing the patient's or patient's legal representative signature — Date — Time

Valley View Surgery Center

Anesthesia Consent

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Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS571

Next of Kin/*Pariente Próximo*

Name/*Nombre*: Carole DiVito Relationship/*Relacion*: Mother

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702-610-6140

In Case of Emergency, I authorize VVSC to Contact:

En caso de Emergencia, yo autorizo a VVSC contactar a

Name/*Nombre*: Misty Freeman Relationship/*Relacion*: daughter

Address and/or telephone number/*Domicilio o Numero de Telefono*: 702 525-9081

I authorize VVSC staff to discuss my medical care with / *Yo autorizo al personal de VVSC para discutir mi cuidado medico con:*

Name of person(s) / *Nombre de persona (s)* Carole DiVito/Marissa Freeman

---

Advanced Directive / *Directivas Anticipadas*: (not applicable for patients under 18 years of age / *no es aplicable a pacientes menores de 18 años*)

Information regarding Advanced Directives is included in the Patient Information Packet /
La informacion sobre Directivas Anticipadas esta incluida en su paquete de informacion

_____ **I do** have an advanced directive / ***Si tengo** una Directiva Avancada;*

- A copy is provided to VVSC: **Yes** **No** / *Se propociona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive /
  Yo entiendo que es mi responsabilidad informar a mis medicos de mi Directiva Anticipada.

✓ **I do not** have an advanced directive / ***Yo no** tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet/*Reconocimiento de paquete de informacion de paciente*:
As required by CMS (federal regulation), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (regulacion federal), por escrito y la notificacion n verbal sobre los Derechos y Responsabilidades de los Pacientes, directivas anticipadas y la politica correspondiente de la instalacion, y una lista de los dueños del negocio de VVSC se da a los pacientes. La firma debajo confirma que la a recibio por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☑ Received with previous date of service / *Recibido con la fecha anterior del servicio*

X _____ Date / *Fecha*: 5/8/17

Patient/Patient Representative signature (if other than patient; relationship:_____

JS572

Valley View Surgery Center
Patient Acknowledgements

Patient label
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

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Patient Valuables and Belongings List

Jewelry	How Many?	With Family	With Patient	In Safe	Comments
Watch	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Ring (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Necklace (s)	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Bracelet	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Earrings/Piercings	[ ]	[ ]	[ ]	[ ]	Color: [ ]Yellow [ ] White
Valuables					
Unopened Purse/wallet	[ ]	[ ]	[ ]	[ ]	
Keys	[ ]	[ ]	[ ]	[ ]	
Cell Phone	[ ]	[ ]	[ ]	[ ]	
ID Card	[ ]	[ ]	[ ]	[ ]	
Ins. Card	[ ]	[ ]	[ ]	[ ]	
Credit Card	[ ]	[ ]	[ ]	[ ]	
Check Book	[ ]	[ ]	[ ]	[ ]	
Money/Currency	[ ]	[ ]	[ ]	[ ]	Amount $_____ [ ] Placed in enclosed envelope/secured VVSC safe.
Clothing					
Blouse/ Shirt	[ ]	[ ]	[ ]	[ ]	
Pants/Shorts	[ ]	[ ]	[ ]	[ ]	
Coat/Sweater Jacket	[ ]	[ ]	[ ]	[ ]	
Dress/Skirt	[ ]	[ ]	[ ]	[ ]	
Shoes/Slippers/Socks	[ ]	[ ]	[ ]	[ ]	
Hat/Belt/Vest	[ ]	[ ]	[ ]	[ ]	
Bra/slip/ Undergarments	[ ]	[ ]	[ ]	[ ]	
Equipment					
Cane/Walker/ Crutches	[ ]	[ ]	[ ]	[ ]	
Wheelchair/ Scooter	[ ]	[ ]	[ ]	[ ]	
Other	[ ]	[ ]	[ ]	[ ]	
*Eyeglasses/ Sunglasses	[ ]	[ ]	[ ]	[ ]	*In labeled Ziplock bag
Dentures/partials	[ ]	[ ]			

Patient Agreement at the time of Admission and Discharge

I understand that Valley View Surgery Center is NOT responsible for my personal belongings. I understand that I have been advised to leave my jewelry/valuables at home or with my responsible adult At VVSC.

PreOp

Patient/Representative (if patient is unable to sign): Joyce P Sekera

RN Witness: Nesru **Date:** 5/8/17

PACU/Discharge

Patient/Representative (if patient is unable to sign): X Joyce P Sekera

[redacted]

[ ] RN [ ] CNA Witness: [illegible] **Date:** 5/8/17

Valley View Surgery Center

Patient Valuable and Belongings

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Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS573

The injection you received contained an a[redacted]tic or an anti-inflammatory steroid medicatio[redacted]both. You could possibly experience a decrease in your pain, numbness and/or weakness due to the anesthetic. The numbness and/or weakness usually lasts 2-8 hours and can at times last longer (should not be longer than 24 hours). Upon the anesthetic wearing off, you may experience some pain at the injection site and/or a temporary increase in your everyday pain. The increase of pain should decrease as the anti-inflammatory medication starts to take effect. This usually takes 3 to 5 days or possibly longer. Ice packs can be used to treat pain and/or inflammation at the injection site although ice packs should NOT be used for more than 20 minutes at a time.
Please refer to your doctor's instructions for ALL PROCEDURES to include limitations of activities, changes with your medications and his/her specific requirements.

[✓] Call your physician's office to schedule a follow up appointment.
[ ] If you are diabetic and received a steroid injection, check your blood sugar twice daily for one week and call your internal medicine physician if your blood sugar is 250 or greater.
[✓] Call your physician's office/answering service if you have any of the following symptoms…

- > Severe headache and/or seizures.
- > Loss of ability to feel or move your arms or legs
- > Infection (redness, swelling, drainage or fever greater than 101.5 F)
- > Heavy pressure over the chest or palpitations (rapid heartbeat)
- > Bleeding at the injection site that is not stopped within 15 minutes of direct pressure.
- > Difficulty breathing and/or speaking.
- > Adverse reaction to the medication given
- > Chills and/or sweating
- > Difficulty speaking and/or confusion

[ ] As ordered by your physician: You are to resume _____ in _____ days. [✓] N/A
Anticoagulant medication

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, CALL 911 OR GO TO THE NEAREST EMERENCY ROOM.

Dr. Travnicek
702-878-8252

c#

Due to the injection procedure as well as the sedation you received during the procedure, DO NOT operate machinery, drive a vehicle, use stairs, drink alcoholic beverages, engage in any strenuous activities until the numbness has completely worn off and your full strength has returned. Do not sign legal documents for at least 24 hours if you were sedated for the procedure.

SPECIFIC INSTRUCTIONS AND/OR EXPECTATIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

[ ] EPIDURAL INJECTION/ SELECTIVE NERVE ROOT BLOCK
[ ] LUMBAR SYMPATHETIC BLOCK
[ ] SACRO-ILLIAC JOINT INJECTION
[ ] FACET JOINT INJECTIONS
[ ] KYPHO/VERTEBRALPLASTY
[ ] INTRATHECAL INJECTION
[ ] DISCOGRAM
[ ] ALL OTHER PROCEDURES

As mentioned above, you may experience weakness in the back, arms and/or legs depending on the injection as well as an increase in pain after the anesthetic wears off. You should relax for the remainder of the day.

[✓] **MEDIAL BRANCH BLOCKS**
This is a diagnostic procedure using an anesthetic. A steroid might also be used depending on your doctor's preference. You should return to normal activity, which usually causes your neck or back pain to see if the procedure effectively reduces or eliminates your pain. This will be temporary lasting only for hours. You should keep a diary/journal and record how much your pain has been reduced and for how long. Bring this diary/journal with you to your follow-up appointment.

[ ] **STELLATE GANGLION BLOCK**
It is normal for your eyelid to droop, facial droop, hoarseness, numbness and/or weakness in your arm or face on the side of the injection. These symptoms should subside in 4 to 8 hours. If you develop any "stroke like" symptoms, such as slurred speech, unable to speak, confusion or unable to move your arms or legs, call 911 immediately or go to the nearest emergency room.

[ ] **TRIGGER POINT INJECTIONS** [ ] **INTERCOSTAL/PERIPHERAL NERVE BLOCK**
If any shortness of breath occurs, please call your physician. In cases of moderate to severe difficulty breathing call 911 or go to the nearest emergency room.

[ ] **RADIOFREQUENCY / RF / NERVE ABLATION DENERVATION**
You may experience more pain or discomfort after the procedure when the anesthetic wears off. This increase of pain can last 1 to 2 weeks and should gradually reduce while the radiofrequency procedure takes effect.

[ ] **TRIAL OR PERMANENT SPINAL CORD STIMULATOR** [ ] **SPINAL (INTRATHECAL) PAIN PUMP**
Both your physician and the equipment company representative will provide you with information relative to the equipment and the procedure. Please follow the instructions provided by your physician and the representative.

[✓] **Copy given to patient:** **DATE:** 05 / 08 / 17 **TIME:** 11:50 (AM) PM

Patient's Signature Joyce P Sekera **Witness Signature** Renee

Discharged to: Carol **Relationship:** mother

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Valley View Surgery Center
Discharge Instructions – Pain Management

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 61
DR: TRAVNICEK, KATHERINE M.D.
DOS: 05/08/17 SEX: F

JS574

West Las Vegas Surgery Center, LLC
d/b/a Valley View Surgery Center
1330 Valley View Blvd
Las Vegas, NV 89102
Tel: (702) 675-4600
Fax: (702) 333-4316

Patient Name: Sekera, Joyce

Declaration of No FILMS **Patient's MR#** 153654

Patient's DOB: 3/22/1956

To: Whom it may concern:

Our facility Valley View Surgery Center and or Medical District Surgery Center does not provide services for the following:

1. X-Rays
2. Radiology Films
3. CT Scans
4. MRI's

Terry Gregg
Custodian of Records

Signature

3/16/17
Date

VALLEY VIEW SURGERY CENTER (VVSC) PATIENT REGISTRATION

Patient Information:

Name	Birthdate	Age	Sex	ACCT#
JOYCE P SEKERA	**03/22/56**	**60**	**F**	**153654**

Address: **7840 NESTING PINE PL, Las Vegas, NV 89143**
Race: **Unknown** | Social Sec #: **091488430** | Marital Status: **U**
Home Phone: **(702)467-5457** | Cell Phone: | Work Phone:
Employer: **N/A**

Guarantor: **SEKERA, JOYCE P** | Patient's Relationship: **Self**
Address: **7840 NESTING PINE Las Veg NV 89143** | Phone: **(702)467-5457**

Primary Insurance:

Carrier: **LIEN PAYER**
Claims: **ATTY; KEITH GALLIHER**
Address: **1850 E. SAHARA #107, Las Vegas, NV 89104**
Ins. Phone: **(702)735-0049**

Insured: **SEKERA, JOYCE**
Patient's Relationship: **Self** | Sex: **F**
DOB: **03/22/1956** | SS#: **091-48-8430**
Insurance ID: **00000000000** | Group #:
Auth #: **APPROVED**
Employer: **N/A**

Secondary Insurance

Carrier:
Claims:
Address
Ins. Phone:

Insured: ,
Patient's Relationship: | Sex:
DOB: | SS#:
Insurance ID: | Group #:
Auth #:
Employer:

Date of Surgery: 03/09/2017 **Surgeon: TRAVNICEK, KATHERINE, M.D.**

Procedure: ****NO SEDATION** BI**
PreOp DX: **M54.5**
Type of Service: **Pain Management LUMB**

Authorization for treatment: I hereby authorize treatment at Valley View Surgery Center
I hereby authorized and permit VVSC to release medical billing data relating to this service
Financial agreement and assignment of payment/benefits: I understand that I am financially responsible for all charges incurred regardless of insurance coverage. I hereby verify that the insurance information that I have provided is correct and that VVSC will bill my insurance for services received. I hereby assign payment of all surgical and/or medical benefits payable on my behalf to VVSC for services at VVSC, not to exceed charges. Any unpaid deductible and/or estimated co-pay is due and payable on the day of service. The account is expected to be paid in full within 90 days from the date of service.
In the event my account is referred to a collection service due to lack of payment on my part, I acknowledge that there may be additional collection/legal fees added to my account.

Returned check charge: I understand that if a payment by check is returned unpaid by my bank for non sufficient funds (NSF), there will be a NSF fee charged to my account not to exceed $50.00. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

Acknowledgement of receipt of HIPAA privacy notice information and Patient Rights & Responsiblities.

Received this date, Initial: JS Received previously, Initial: _____

Signed: Joyce Sekera **Date:** 3/9/17

Relationship if other than patient: _____

Witnessed by: _____

JS576

NAME: **SEKERA, JOYCE P**
ACT#: **153654**
DOB: **03/22/56** AGE: **60**
DR: **TRAVNICEK, KATHERINE M.D.**
DOS: **03/09/17** SEX: **F**

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: March 9, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic and therapeutic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT INJECTION(S) BILATERAL L5-S1
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a styletted procedure needle was inserted percutaneously and directed to the posterior aspect of each facet joint to be injected without paraesthesia. Each site was then injected with contrast to confirm flow into the joint and to rule out intravascular or intrathecal injection. Each joint was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood and cerebrospinal fluid. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.
CONTRAST: Omnipaque
INJECTATE (each site): Dexamethasone 4 mg (pf) in Marcaine (pf) 0.5% final concentration. 1 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 3/09/2017 Time: 11:21:44

JS577

SCHEDULED PROCEDURE: ~~Outpatient~~ ESI's. Bilateral Lumbar S-Sacral, FJI

CHIEF COMPLAINT/ REASON FOR PROCEDURE:

- ☐ Head pain
- ☐ Neck pain
- ☐ Upper extremity pain
- ☐ Mid back pain
- ☑ Low back pain
- ☐ Sacral pain
- ☐ Lower extremity pain
- ☐ Other: _____

MEDICAL HISTORY: ☐ Other _____

See Pre-Anesthesia Record

Current medications - see Patient Home Medication List (Medication Reconciliation List)

HISTORY OF PREVIOUS PAIN MANAGEMENT PROCEDUDRE:

- ☑ No
- ☐ Yes

Justification for repeat Epidural Steroid Injection

- ☐ Partial Improvement
- ☐ Transient Improvement
- ☐ Significant Improvement
- ☐ Return of symptoms
- ☐ Persistent symptoms
- ☐ Other _____

SOCIAL/ FAMILY HISTORY:

- ☑ Non Contributory
- ☐ Other _____

ALLERGIES or ABNORMAL DRUG REACTIONS: ☑ NKA ☐ _____

PHYSICAL EXAM:

Heart/Cardiac _____

Lungs/Respiratory _____

Other _____

MSedaka

PLANNED ANESTHESIA:

- ☐ Anesthesiologist
- ☑ VVCS-RN **ASA Score:** ☑ 1 ☐ 2 ☐ 3 ☐ 4

PRE-OPERATIVE DIAGNOSIS:

☑ Spondylosis (facet pain)	☐ Cervical	☐ Thoracic	☑ Lumbar
☐ Spondylosis w/o myelopathy	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Displacement of intervertebral disc	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Degeneration Disc Disease	☐ Cervical	☐ Thoracic	☐ Lumbar
☐ Post Laminectomy Syndrome	☐ Cervical	☐ Thoracic	☐ Lumbar

☐ Other _____

ABNORMAL FINDINGS TO BE ADDRESSED ON DATE OF SERVICE PRIOR TO PROCEDURE: ☐ NA

_____ _____ MD'S Signature ☐ Proceed ☐ Cancel procedure

I have discussed with my patient the surgical or invasive procedure to be performed along with the benefits and risks of the procedure and alternative options. Informed consent was discussed with the patient, including the risks, benefits, potential complications, and any alternative options associated with the planned procedure and anesthesia. The Patient is cleared for procedure in VVSC.

DISCHARGE NOTE:

Complications ☑ None

☐ Other: _____

Condition Stable: ☑ Discharge to home

Physician signature: _____

Valley View Surgery Center

Pain Management History & Physical

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/12 SEX: F

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JS578

Date / Nurse Notation	STANDING ORDERS
	PRE-OP ORDERS: Admit to Valley View Surgery Center for scheduled procedure on consent.
	1. Urine pregnancy test on females having periodic menstrual cycles unless post hysterectomy or no menstrual period for more than a year. Results of Pre-Op blood or urine tests completed 7 days or less prior to procedure will be accepted for pregnancy screening.
	2. Obtain BP, Blood Sugar and HCG results (if applicable) on patients **prior** to having the patient change for the procedure.
	3. Do blood glucose level on all diabetic patients. Report results greater than 150.
	4. Insert 20G IV cath for Saline lock or IV solution. Flush w/ 3 mls 0.9% NS PRN. May use 0.5% Lidocaine 0.1-0.2mls subcutaneous before insertion. Start IV 0.9 NS 250 mls KVO on non-operative side for cervical procedures.
	5. -Discograms: Ancef 1900mg IVP/IVPB (Ancef 2900mgs IVPB for patients 120kg or greater) -Hardware Blocks, Implants, Plexus Block, Pump Refills, Superior Hypogastric Block †TSCS and patients with history of MVP, and Subacute Bacterial Endocarditis: Clindamycin 900mg IV.
	7. For cervical transforaminal injections, give Ondansetron (Zofran) 4mg IVP over two to 5 minutes.
	8. For Stellate Ganglion and Sympathetic injections, record a baseline temperature on appropriate bilateral extremities.
	9. Document the date patient discontinued any of the following medications. Acceptable days of discontinuance from date of procedure: [ ]ASA–7days, [ ]Coumadin or [ ]Plavix- for7 days, [ ] Except for Celebrex, all non-steroidal anti-inflammatory medications for 4 days. Inform MD if days do not meet criteria.
	10. For blood patch procedures Using sterile technique, insert at minimum a 20G IV catheter (preferable 18G) in the antecubital vein as the second IV site for blood draw
	Surgical Consent to read (CHECK ALL THAT APPLY):

CERVICAL ———— **[ ] Left [ ] Right [ ] Bilateral**
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection) ***
[ ] Stellate Ganglion [ ] Radiofrequency [ ] Discography [ ] Greater/Lesser Occipital
LEVELS: [ ]C2 [ ]C3 [ ]C4 [ ]C5 [ ]C6 [ ]C7 [ ]C8 [ ]C1-2 [ ]C2-3 [ ]C3-4 [ ]C4-5 [ ]C5-6 [ ]C6-7 [ ]C7-T1

THORACIC ———— **[ ] Left [ ] Right [ ] Bilateral**
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)*** [ ] Radiofrequency [ ] Discography
LEVELS: [ ]T6 [ ]T7 [ ]T8 [ ]T9 [ ]T10 [ ]T11 [ ]T12 [ ]T6-7 [ ]T7-8 [ ]T8-9 [ ]T9-10 [ ]T10-11 [ ]T11-12 [ ]T12-L1

LUMBAR ———— **[ ] Left [ ] Right [ ] Bilateral**
[ ] Epidural Steroid Injection [ ] SNRB* [ ] TFESI** [ ] Facet Joint Injection [ ] MBB (Facet Nerve Injection)***
[ ] Sympathetic [ ] Radiofrequency [ ] Discography [ ] Caudal/Catheter Directed [ ] Sacroiliac Joint
LEVELS: [ ]L1 [ ]L2 [ ]L3 [ ]L4 [ ]L5 [ ]S1 [ ]S2 [ ]L1-2 [ ]L2-3 [ ]L3-4 [ ]L4-5 [ ]L5-S1
OTHER: [ ] †TSCS [ ] Dutenhar any
UNDER FLUOROSCOPY †TSCS Trial Spinal Cord Stimulator
*SNRB=Selective Nerve Root Block **TFESI=Transforaminal Epidural Steroid Injection ***MBB=Medial Branch Block

INTRAOPERATIVE ORERS. Oxygen at 2-4 L/NC **CONSCIOUS SEDATION** [ ] Versed _____mg [ ] Alfentanil _____mcg
[ ] Propofol _____mgs [ ] Fentanyl _____mcg [ ] Romazicon _____mg

For Radiofrequency Treatment: See RF Neurotomy Procedural Notes Form. Medications drawn up as ordered on MD preference cards.

	PACU ORDERS
	1. Check vitals every 5 minutes x 2 then up to chair/dangle with 1 set of vitals. Record post-procedure temperature readings on patients who received Stellate Ganglion and Sympathetic injection procedures. If local infiltrate and no sedation performed, take vital signs x1. Discharge when patient stable.
	2. For Stellate Ganglion and Sympathetic injections, record temperature on appropriate bilateral extremities.
	3. Oxygen nasal prongs or mask to as needed to maintain pre-op oxygenation level.
	4. Ice chips or liquids as tolerated. Ondansetron 4mg IVP/IM for nausea or vomiting prn.
	5. Do blood sugar testing if pt. received treatment for blood sugar level.
	6. Remove IV catheter just before discharge.
	7. Resume all prior medications. [ ] NA
	8. Resume all anticoagulants on next scheduled dose after the procedure. [ ] NA
	9. Provide and review written copy of post procedure instructions with patient & family members.
	10. Pt may be discharged in ½ hr if post-reversal agent. [ ] yes [ ] no
	11. Other orders:

PHYSICIAN'S SIGNATURE: _____

VALLEY VIEW SURGERY CENTER
Standing Orders - K. Travnicek, M.D.

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JS579

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: March 9, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic and therapeutic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT INJECTION(S) BILATERAL L5-S1
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a styletted procedure needle was inserted percutaneously and directed to the posterior aspect of each facet joint to be injected without paraesthesia. Each site was then injected with contrast to confirm flow into the joint and to rule out intravascular or intrathecal injection. Each joint was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood and cerebrospinal fluid. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.
CONTRAST: Omnipaque
INJECTATE (each site): Dexamethasone 4 mg (pf) in Marcaine (pf) 0.5% final concentration. 1 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 3/09/2017 Time: 11:21:44

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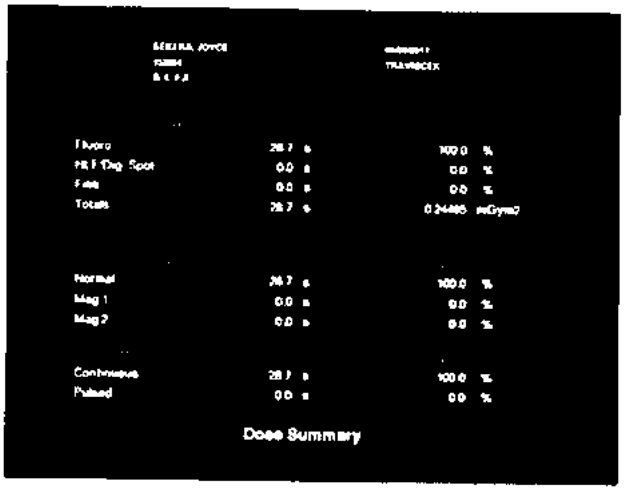
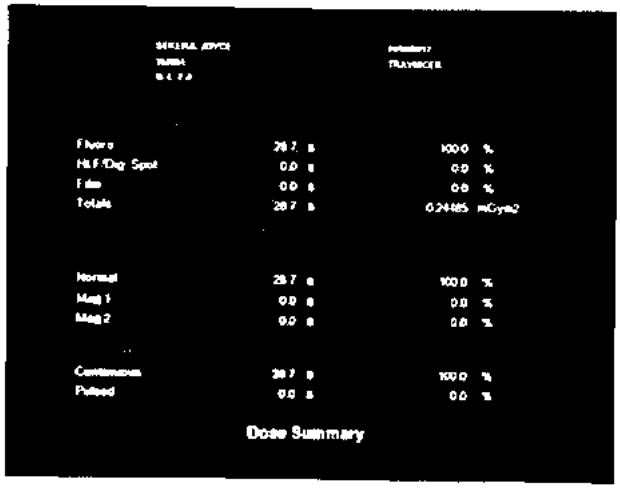
JS580





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Valley View Surgery Center

Fluoroscopic Images

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Patient label

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JS581

Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure.	Greet patient, check two patient identifiers and verify operative site, allergies and other pertinent information. Safety straps applied. patient positioned appropriately with good body alignment and pressure points padded.	Operative site, correct patient and permanent history verified. Allergies noted. Patient encouraged to ask questions about care in the operating room. Proper body alignment and safety straps used. Electrical equipment checked and ensured to be in safe condition	CM Initials:

ALLERGIES: ☒ NKA ☐ See Front of Chart

TX # 1 Time in TX: 1000 "TIMEOUT" by CM,VAL @ 1005 w/MD and all listed staff present

Time PROCEDURE BEGAN: 1008 Time PROCEDURE ENDED: 1013 TIME PT LEAVING TX 1015

If STAGED in room or change in position/different site area:

"TIMEOUT" by ____@____w/MD and all listed staff present

Time PROCEDURE BEGAN: Time PROCEDURE ENDED: TIME PT LEAVING TX

NO SEDATION

PAIN MANAGEMENT PERSONNEL

DR. PERFORMING PROCEDURE: Dr. K. TRAVNICEK ANESTHESIA: ☐ IVCS ☐ MAC ☒ LOCAL INFILTRATE ☐ GENERAL ☐ OTHER

☐ ANESTHESIOLOGIST ☒ IVCS NURSE V.IRIZARI,RN CIRCULATOR C.BUTTERLING,RN

MED NURSE A. REUGHIN,RN ☐ N/A SCRUB L.ARIAS X-RAY S.SCIRE OTHER

MEDICATIONS GIVEN BY PHYSICIAN DURING THE PROCEDURE:

☐ 1% Lidocaine MPF ☒ 0.5% Bupivacaine MPF ☐ 0.9% Normal Saline ☒ Omnipaque 300 mg plain

☒ 2% Lidocaine MPF ☒ Dexamethasone ☐ Myoblock ___ Units ☐ Omnipaque 300 mg Added ☐ Ancef ___ mg

☒ 4% Lidocaine MPF ☐ Methylprednisolone ☐ Pump medication verified with attending MD

(The dose and route of the medications given are noted on the procedural report of the physician performing the procedure.)

PRE-OP DIAGNOSIS: LUMBAR SPONDYLOSIS

PROCEDURE: [ ] Cervical [ ] Thoracic [X] Lumbar [ ] Caudal [ ] Hip [ ] Knee [ ] Shoulder (Number multiple procedures in sequence)

[ ] Discography

[ ] Epidural Steroid Injection

[X] Facets: [ ] Right [ ] Left [X] Bilateral

[ ] Intercostal Nerve Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Medial Branch Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Occipital, Greater/Lesser: [ ] Right [ ] Left [ ] Bilateral

[ ] Radiofrequency: [ ] Right [ ] Left [ ] Bilateral See RF Neurotomy Procedural Notes Form

[ ] Sacroiliac Joint: [ ] Right [ ] Left [ ] Bilateral

[ ] Selective Nerve Root Block: [ ] Right [ ] Left [ ] Bilateral

[ ] Stellate Ganglion: [ ] Right [ ] Left [ ] Bilateral

[ ] Sympathetic Block, Lumbar [ ] Right [ ] Left

[ ] Transforaminal epidural steroid injection: [ ] Right [ ] Left [ ] Bilateral

[ ] Trial Spinal Cord Stimulator [ ] Trial Pain Pump [ ] Other

Prep to operative site: ☐ Duraprep ☒ Chloraprep: ☐ Tinted ☒ Clear **By:** L.ARIAS

Positioning: ☐ Supine ☒ Prone ☐ Lateral ☐ Arms tucked ☒ Pillows for positioning

☐ Padded toboggans used for arm protection ☒ Safety strap on x 3

POST OP DIAGNOSIS ☒ SAME ☐ Other ☐ Pain log given

Notes:

☐ Radiation Skin Status - Pre Radiation ☒ All Clear Post Radiation ☒ All Clear

CIRCULATOR SIGNATURE C.BUTTERLING,RN

Valley View Surgery Center

Pain Management OR Record

Dr. K. Travnicek

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JS582

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Pre-OP Vitals BP 140/81 HR 46 RR 16 O_2 Sat 96% ☑ Room air ☐ Oxygen @ ___ L/min Temperature 96 °F

ALLERGIES ☐ NKA ☐ See Front of Chart

	Time	1000	1005	1010														
Legend: v = Systolic BP, ^ = Diastolic BP, • = Pulse	220																	
	210																	
	200																	
	190																	
	180	v	v															
	170			v														
	160																	
	150																	
O_2 Appliance: ☑ Cannula ☐ Mask	140																	
O_2 Liter Flow @ 3 L/min	130																	
ECG: ☑ NSR	120																	
☐ Sinus Bradycardia	110																	
☐ Sinus Tachycardia	100																	
☐ Other:	90		^	^														
IV Site: ☑ Right arm	80																	
☐ Left arm	70	^																
☐ Other:	60																	
Condition: ☑ Patient	50	•	•	•														
☐ Other:	40																	
Solution: ☑ Saline Lock	30																	
☐ Isolyte ☐ 0.9% NaCl	SaO_2	100	100	100														
☐ Other:	RR	16	16	16														
Acceptable range 35-45mmHg	ETCO2	38	38	38														
ETCO2 Waveform present ✓		✓	✓	✓														

CONSCIOUS SEDATION SCALE			
Respirations: 0. Appear Adequate 1. Impaired exchange 2. Dyspnea/Obstructed	0	0	0
Level of Consciousness: 0. Alert or awakening 1. Follows commands / Intermittent arousal 2. Unresponsive	0	0	0
Vital Signs: 1. Increase (+ 21% of pre-anesthetic level) 2. Within acceptable limits 3. Decrease (- 21% of pre-anesthetic level)	2	2	2
Physical / Emotional Affect: 0. Resistive / Intense / Anxious / Uneasy 1. Tempered or Intermittent response / Calm / Tolerant 2. No response	1	1	1
Total Sedation scale (Optimal 3-5)	3	3	3

MEDICATIONS	DOSAGES
☐ Versed IV mg	
☐ Fentanyl IV mcg	
☐ Alfentanil IV mcg	No sedation
☐ Propofol IV mg	
☐ Romazicon IV mg	
☐ Narcan IV mg	
☐ Cefazolin IV mg	
☐ Other:	

IVCS RN Printed Name: V IRIZARI **Signature:** V. Irizari **Initials** VI

Antibiotic: ☐ ~~NA~~ ___ **completed at** ___ **By** ___

☑ Patient tolerated procedure well and was transferred to PACU in apparent good condition

☑ Report given by IVCS/circulating nurse and care handed over to **PACU Nurse** J. Chambers R

VALLEY VIEW SURGERY CENTER
IVCS by RN

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JS583

Nursing Diagnosis	Outcome/Goal	Plan	Interventions/Implementation	Comments
Potential injury to patient peri-operatively	Patient will not acquire injury throughout the peri-operative procedure	Ensure immediate , on-site availability of back-up personnel for airway management, resuscitative emergency intubation and emergency equipment	Emergency equipment will be present, working properly and immediately available in the room where the procedure(s) are performed Nursing assessment conducted by IVCS nurse including pertinent medical history, verification of allergies, confirmation of NPO status	
Potential decrease in blood pressure, heart rate, peripheral resistance and oxygen saturation, especially during administration of sedation agent(s)	Patient vital signs will remain within patient's normal limits as evident by the utilization of monitoring equipment peri-operatively	Explain monitoring equipment and ECG pads to patient	ECG electrodes, blood pressure cuff and pulse oximeter applied prior to procedure Vital signs will be monitored continually throughout the procedure at a minimum before the start of procedure, one minute after administration of medication(s) given, and at least every five minutes thereafter until procedure is completed	
Potential for anxiety and pain related to therapeutic and/or diagnostic procedures	Patient will be able to tolerate diagnostic and/or therapeutic procedures with reduced anxiety and discomfort. Patient's LOC will be mildly depressed with an altered perception to pain, but will retain the ability to respond appropriately to verbal and/or tactile stimulation	Sedation agent(s) will be administered per physician's orders	Pts LOC will be assessed at regular intervals, verbal reassurance will be given to divert patient's attention and assist in reducing anxiety	Initials:

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Date: 3/9/17 Monitors On [x] Alarms Set [x] Allergies: ______ [x] NKA

Procedure: (B) L F J Inj [ ] See Front of Chart

PreOp: B/P 140/81 Pulse 48 RR 16 SaO₂ 96 % [x] RA [ ] @ ___ L/min Temp: 96.8 Pain Level: 4/10 Initials S.

ADMIT TIME	BP	PULSE	RESP	O2 SAT ___L	RA	TEMP	PAIN LEVEL
1015	135/78	48	18	99		96.9	5/10
1020	139/76	48	16	96			5/10
1025	131/92	48	18		97		5

POST ANESTHESIA ASSESSMENT RECOVERY SCORE		ADM	DISCHARGE
Purposeful movement of all extremities =2 Moves two extremities =1 No movement of extremities =0	Activity	2	2
Breath deeply and cough freely =2 Limited and/or impaired breathing =1 Apnea =0	Resp	2	2
BP stable or improved over PreOp readings. Pt. asymptomatic = 2 Pt. outside of acceptable range based on PreOp readings. =1 Unstable Hypotension or Hypertension = 0	Circ	2	2
Alert, fully awake, responding appropriately =2 Responds to name and/or verbal stimuli =1 Unresponsive =0	LOC	2	2
Normal skin color/SpO₂ > 92% on room air = 2 Pale, Supplemental O₂ for SpO₂ > 90% =1 SpO₂ < 92% with O₂ supplementation =0	Color	2	2
Totals:			
DISCHARGE CRITERIA SCORE 10 or pre anesthesia		10	10

TIME	MEDICATION / DOSE / ROUTE / SITE FOR IM OR SQ INJECTIONS	PAIN LEVEL	INITIALS
Ø			

NURSES NOTES - (Must make comments for * outcome discharge answers)

[ ] Pt. given pain log and understands instructions as noted by pt.'s verbalization. [ ] NA

[ ] Time: 1142 Pt. up in wheelchair. Medically discharged. Waiting for ride

Signature		Initials	
Signature	[signature]	Initials	JC

DISCHARGE

Pt. tolerated procedure without apparent injury: [ ] Yes [ ] No*

Safety maintained: [ ] Yes [ ] No*

LOC: [x] Alert [ ] Oriented same as PreOp level [ ] Sedated* [ ]

[ ] Nausea/Vomiting [ ] NA [ ] Minimal/Not treated [ ] Treated

Intake: PO 60 mls IV Ø mls

Discharge Criteria Met: [x] Yes [ ] No*

IV catheter removed / catheter intact: [x] Yes [ ] No*

S/S of complications due to IV: [x] No [ ] Yes*

Copy of post op instructions given to pt./other: [ ] Yes [ ] No*

Prescription given. [ ] NA [ ] Yes If yes, instructed pt. to take medication as written on prescription [x] Yes [ ] No

Instructed pt. to resume medications as instructed / ordered by MD [x] Yes [ ] No

Pt./other states understanding of all instructions: [x] Yes [ ] No*

Mobility unchanged from Pre Op level: [ ] Yes [x] No*

Discharged via w/c to responsible adult: [ ] Yes [ ] No*

Discharge Pain Level Ø Discharge Time: 1144

VALLEY VIEW SURGERY CENTER

POST PROCEDURE RECORD

Patient Label

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JS585

POST-OPERATIVE PATIENT CARE

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Altered airway Function Post-anesthesia	• Observe & maintain or support airway as needed • O_2 on arrival / PRN • Monitor SaO_2 • Appropriate position	Patient airway with maximum respiratory compliance as evidenced by adequate O_2 exchange, tissue perfusion & visible hemodynamics. Clear airway without assist	Goal is obtained: ☐ Yes ☐ No Comments:
Altered hemodynamics potential for hypovolemia	• Monitor EDG for arrhythmia • Note/Intervene for B/P +/- 50% of pre-op reading • Observe surgical site for bleeding	Stable hemodynamics	Goal is obtained: ☐ Yes ☐ No Comments:
Altered level of consciousness	• Stimulate adult patient PRN • Do not stimulate pediatric patient if airway & hemodynamics are stable • Orient patient to surroundings • Observe for altered L.O.C.	Patient will be arousable, oriented and as alert as possible prior to discharge	Goal is obtained: ☐ Yes ☐ No Comments:
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety Able to verbalize pos-op instructions (i.e. diet, wound care, pain control & activity)	Goal is obtained: ☐ Yes ☐ No Comments:
Potential Injury	• Utilize side rails (pads PRN) • Place bed in low position • Secure IV's and assess for patency • Ensure correct physiological positioning	No injury in PACU	Goal is obtained: ☐ Yes ☐ No Comments:
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Relief of pain verbalized using pain scale	Goal is obtained: ☑ Yes ☐ No Comments:
Nausea & Vomiting ☐ N/A	• Recognize nausea • Medicate as ordered • Teach relaxation techniques • Position for comfort & to prevent aspiration	Relief of nausea verbalized	Goal is obtained: ☐ Yes ☐ No Comments:

Initials of Nurse

Nurses Notes Continued as needed:

If EKG strip affixed to record, complete the following.

Time _____ am/pm

Dr. _____ notified @ _____ am/pm

Per MD's order: ☐ No treatment
☐ Treatment: _____

Signature of RN: _____ Time: _____ am/pm

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Date: 3/9/17 Time Admitted: 0910 **PRE-OP CHECKLIST** 702-525-9001

Pt. identified by ☑ full name ☐ date of birth by S From: ☑ Home ☐ Other _____ Via: ☑ Walking ☐ Wheelchair ☐ Carried

Planned Procedure: R/L L5-S1 FJI NPO since: 2200 AM Meds: ☐ Yes ☑ No

Responsible Adult taking pt. home: Dawsn+Cr Driver: Marisa ☐ Same ☐ Waiting ☐ Call at: _____

MEDICAL HISTORY: ☐ Asthma ☐ Ulcers ☐ Hiatal Hernia ☐ TMJ ☐ SOB ☐* Diabetes ☐ MVP ☐ Stroke ☐ Sleep Apnea ☐ Hepatitis
☐ Hypertension ☑ Smoker ☐* Chest Pain/Previous MI (Date _____) ☐ Palpitations ☐ Seizures ☐ Back/Neck Problems
☐ Thyroid Problems ☐ AIDS/HIV Positive ☐ Street Drugs ☐* Arthritis ☐* Osteoporosis ☐ Other/Notes: _____

SURGICAL HISTORY: ☐ Tonsils/Adenoids ☐ Gallbladder ☐ Hysterectomy ☐ CABG ☐ Hernia ☐ Appendix ☐ Back ☐* Hip
☐ Sinus/Nasal ☐ Biopsy _____ ☐ D&C ☑ Laparoscopy ☐ Metal Implants ☐ Pacemaker/ICD ☐ Foot ☐ Cervical
☐ Knee ☐ Eye Surgery ☐ Other/Notes: 02 22.

Medication list: See Pre-Anesthesia Record and Patient Home Medication List

VITAL SIGNS: Weight 94 Kg lb Height 66" ALLERGIES: ☑ NKA

SaO_2 96 % ☑ RA @ _____ L/min Temp 96 Y Pulse 79 Resp 16

BP 140/91 ☐ R ☑ L arm Extremity temp: R _____ L _____ ☐ NA ☐ See Front of Chart

SYSTEMS ASSESSMENT ☐* or ☐^ = Fall Risk If ≥4* or ^ checked ☐ Fall Risk Band applied

Respiratory:
- Respiration: ☑ unlabored ☐ labored ☐ other _____
- Breath Sounds: ☑ audible ☐ clear ☐ other _____
- Cough: ☑ absent ☐ non-productive ☐ productive ☐ other Smoker.

Cardiovascular:
- Heart tones: ☑ regular ☐ irregular ☐ other Bcopy, denies dizziness
- Color: ☑ pink ☐ cyanotic ☐ other chest/palpitations/CP.

Neuro Sensory:
- ☑ alert ☑ oriented ☐^ confused ☐ other _____
- **Psychosocial:** ☐ calm ☑ anxious ☐ crying ☐ angry ☐ other Tearful
- **Skin:** ☑ normal ☐ pink ☐ cyanotic
  ☑ warm ☐ cool ☑ dry ☐ diaphoretic ☐ other _____
- **GI / GU:** ☑ normal ☐ incontinent ☐ other _____
- **Activity:** ☑ full ☐ ROM ☐ ^uses assistive device ☐ ^Fall within 3 mo ☐ other _____
- ***Pain Intensity Level:** 0/10 Location: Back / Leg Pain Quality Achy

CHECKLIST	Yes	No	NA
Consent			
H&P	✓		
H&P (Podiatry)			
CXR			
EKG			
CBC			
Coag.			
Urine			
Lytes/Chem panel			
Preg Urine/Serum			
Hepatitis Screen			
HIV			
Bowel prep finished			
Surgical Site Clipped			
Medical Clearance			
TEDs/SCDs			

PREMEDICATIONS:

Times	Medication / Dose	By

Pre-Op teaching done ☑ Yes ☐ No
Discharge inst. given ☑ Yes ☐ No
Patient ride confirmed ☑ Yes ☐ No

Valuables w/	Patient	Family	None
Dentures	✓		✗
Glasses/Contacts			✗
Hearing aids			✗
Clothes	✗		
Jewelry/ Body Jewelry	*See back		✗

TESTING ON UNIT	RESULTS	N/A
Urine Pregnancy	neg.	✓
AccuChek		
☐ FBS ☐ RBS		✓
Normal range FBS 70 – 200 mg/dL		

Procedure or surgery site:
☑ Confirmed w/pt: ☐ right ☐ left ☑ bilateral ☐ NA
☐ Marked by MD
IV started in holding: ☑ Yes ☐ No Attempts ____ Initial S

Flush: ☑ 3 mls NS ☐ IV _____ ☐ _____ mls
Site: ☐ R ☐ L ☐ Superior Dorsal ☐ Anticubital vein
☐ Other: _____ Gauge ☐ 18 ☐ 20 ☐ 22 ☐ 24 Exp: _____
ID band applied by: _____
☑ Pt. tolerated tx. ☐ Other _____

SIGNATURES (Initial)
Diana Shuf (✗)
( )

To OR via: ☐ gurney ☐ side rails up ☐ bed ☐ low ☐ carried ☑ walk in

Valley View Surgery Center
PRE-OP CHECKLIST
M:\FORMS\Clinical forms\PRE OP CHECKLIST rev120716pp

Pain NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS587

PRE-OPERATIVE PATIENT CARE PLAN

NURSING DIAGNOSIS	NURSING INTERVENTION	PATIENT OUTCOME	EVALUATION
Anxiety	• Recognize & acknowledge anxiety • Orient to surroundings • Provide physical comfort • Complete/reinforce post-op teaching	Accepts healthcare measures and has minimal anxiety	Goal is obtained: ✓Yes No Comments: ______
Potential Injury	• Utilize side rails (pads PRN) • Place bed in low position/chair locked • Secure IVs & assess for patency • Ensure correct physiological positioning	No injury in Pre-Op	Goal is obtained: ✓Yes No Comments: ______
Pain	• Recognize and assess pain • Medicate as ordered • Teach relaxation techniques • Position for comfort	Pain verbalized using pain scale	Goal is obtained: ✓Yes No Comments: ______

Pre-Op Nurse Initials S

NURSE'S NOTES

*Confirmed/witnessed with pt.: Jewelry secured in closed plastic bag. Bag placed in pt.'s belonging bag.

Nurse's Initials See List-S.

TIME	
	"I'm afraid of Anesthesia Because when I 22 I had a laparoscopy.
	The gas cause pain in my ABD I had to have a massage massages.
	2 days in the hospital" ———— [signature]

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
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DOS: 03/09/17 SEX: F

Reference: AAAHC Institute for Quality Improvement, *Patient Safety Toolkit: Ambulatory Surgery and Preventing Falls*, 07/22/13

JS588

Height 66" **Actual weight** _____lb.
Estatura Peso
Allergies: NKA.
Alergias:

1. **Have you taken any of the following medications:**
   Ha tomado los medicamentos listados:

Aspirin: ☐ **Yes, date last taken** _____ ☑ No
Aspirina: ☐ Si, ultima fecha tomada

***Plavix:** ☐ **Yes, date last taken** _____ ☑ No
☐ Si, ultima fecha tomado

***Coumadin:** ☑ No
☐ **Yes, date last taken** _____
☐ Si, ultima fecha tomado

Anti-inflammatory: ☑ No
☐ **Yes, date last taken** _____
Anti-inflamatorios
☐ Si, ultima fecha tomado

2. **For female patients only:** ☐ N/A
   Date of last menstrual period_____
   Para mujeres solamente: fecha de su ultima menstruación_____

3. **List all previous surgeries (and when)**
   Lista de todas cirugías previas (con fechas)

4. **Do you symptoms of tuberculosis**
   Ha sido diagnosticado con Tuberculosis-
   -**Productive cough** ☐ Yes ☑ No -**Weakness, Fatigue** ☐ Yes ☑ No
   -Tos productiva -Fatiga, debilidad
   -**Bloody sputum** ☐ Yes ☑ No -**Night sweats** ☐ Yes ☑ No
   -Esputo con sangre -Sudores nocturnos
   -**Unexplained weight loss** ☐ Yes ☑ No -**Fever** ☐ Yes ☑ No
   -Perdida de peso inexplicable -Fiebre

HISTORY HISTORIAL	Yes Si	No
5. **Have or are you taking "street drugs"** **If yes, last date**_____ Ha o está tomando drogas ilegales En caso que si, fecha ultima: _____	☐	☑
6. **Do you use Medical Marijuana?** **If yes, last date:**_____ Utilizas la marihuana medicinal En caso que si, fecha ultima:_____	☐	☑
7. **Have you had recent weight change?** **(Significant amount)** Has tenido cambio significante en peso		

HISTORY HISTORIAL	Yes Si	No
8. **Do you smoke?** **If yes, cigarettes per day:** 4 ¿Fuma? En caso que sí, cuantos cigarrillos per día ___	☑	☐
9. **Do you have caps, false teeth, bridge, partials or contact lenses?** (Not natural teeth.) ¿Tiene dientes falsos, tapas, dentaduras/Puente parsial o lentes de contacto	☑	☐
10. **Do you drink alcoholic beverages?** **If Yes, how much** _____, **last time**_____ ¿Consume bebidas alcolicas? En caso que si, cantidad _____	☐	☑
11. **Have you ever experienced any reaction to rubber or latex products?** Alguna vez ha experimentado una reacción a los productos de goma o látex **If yes, please describe** En caso que si, por favor describa	☐	☑
12. **Glaucoma** Glaucoma	☐	☑
13. **TMJ (dysfunction of temporomandibular joint)** TMJ (disfunción de la articulación temporomadibular)	☐	☑
14. **Stiff neck** Cuello tieso	☐	☑
15. **Shortness of breath** Dificultad para respirar	☐	☑
16. **Asthma** Asma	☐	☑
17. **Heart attack** Ataque de Corazón	☐	☑
18. **Chest pain; angina** Dolor de pecho	☐	☑
19. **Palpitations** Palpitaciones	☐	☑
20. **High blood pressure** Alta presión	☐	☑
21. **Implanted pacemaker/defibrillator** Marcapasos / desfibrilador	☐	☑

CONTINUE ON BACK
CONTINUAR EN LA PARTE POSTERIOR

JS589

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label
NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

HISTORY HISTORIAL	Yes Si	No
22. **Home oxygen** Usa oxigeno en el hogar	☐	☐
23. **Hepatitis** Hepatitis **If Yes /** En caso que si **Type** ☐ A ☐ B ☐ C	☐	☐
24. **Hiatal Hernia** Hernia Hiatal	☐	☐
25. **Previous Colonoscopy?** ¿Colonsocopy anterior? **If Yes, when?** _____ ¿En caso afirmativo, cuando? _____	☐	☐
26. **Rheumatic Fever** Fiebre Reumática	☐	☐
27. **Ulcers** Ulceras	☐	☐
28. **Stroke** Derrame Cerebral	☐	☐
29. **Seizures** Convulsiones	☐	☐
30. ***Parkinson disease** Enfermedad de Parkinsons	☐	☐
31. **Blackouts** Desmayos	☐	☐
32. **Sleep Apnea Bipap / C-pap** Deja de respirar durante la noche	☐	☐
33. **Back / Neck Problems** Problemas de cuello / espalda	☐	☐
34. ***Osteoporosis** Osteoporosis	☐	☐
35. **Muscle Diseases** Enfermedad Muscular	☐	☐
36. **Arthritis** Artritis	☐	☐
37. **Diabetes** Diabetes	☐	☐
38. **Thyroid Problems** Problemas de la Tiroides	☐	☐
39. **Hemophilia** Hemofilia / Desorden de sangrado	☐	☐
40. **Sickle Cell Anemia** Anemia de Celulas falciformes	☐	☐
41. **Blood Transfusion** Transfusión de sangre	☐	☐
42. **Kidney Disease** Enfermedad de Riñones	☐	☐
43. **Dialysis patient?** ¿Paciente de diálisis? **If yes, date of last dialysis?** _____ ¿En caso que Si, fecha de ultimo tratamiento?	☐	☐

HISTORY HISTORIAL	Yes Si	No
44. **Aids / HIV Positive** Sida / VIH Positivo	☐	☐
45. **MVP (Mitral Valve Prolapse)** Prolapso de la valvula Mitral	☐	☐
46. **Metal Implants** Inplantes Metálicos	☐	☐
47. **Cancer** **If Yes, Where**_____ Cancer En caso que Si, en donde_____	☐	☐
48. **Drug resistant infection** **Methicillin resistant Staph Aureus (MRSA)**	☐	☐
49. **Long term antibiotic treatment** Tratamiento de antibioticos a largo plazo	☐	☐
50. **Draining wound** Herida abierta	☐	☐
51. **Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?** ¿Usted o su familiar a tenido fiebre inexplicable durante o despues de cirugia?	☐	☐
52. **Have you traveled outside of country in the past 6 months?** ¿Has viajado afuera de el país en los ultimo 6 meses?	☐	☐

Any additional information you want to communicate?
Alguna otra información que desea comunicar:

_____

_____

_____

_____

_____

Signature (Patient/ or Person filling out form)
(If other than patient; relationship :_____)

Firma (Paciente/representante)
(relación al paciente: _____)

3-9-17
Date/Fecha

Signature of Pre Op Nurse **Date** 3/9/17

* ☐ = Fall risk

Valley View Surgery Center

Pre-Anesthesia Record
(Adult, age 18 and over)
M:\FORMS\Clinical forms\Pre Anesthesia Record 01.2017.doc

Patient Label

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS590

Valley View Surgery Center

PATIENT HOME MEDICATION LIST (As Provided by Patient)

Please fill in highlighted areas only and bring form back to VVSC before or on the day of your procedure.

☐ No Known Allergies

ALLERGIES AND THEIR REACTIONS:

List all medications taken over the past 6 months (Include prescriptions, over the counter, vitamins, herbal supplements, medications via patch, birth control treatment.)

Medication Name	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: 3/9/17 Last Taken (Date/Time)	Date of Visit: ____ Last Taken (Date/Time)	Date of Visit: ____ Last Taken (Date/Time)	Date of Visit: ____ Last Taken (Date/Time)
NONE							

New Prescriptions (Completed by Nurse)	Dose	Frequency (How often?)	Reason for Taking	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt. Copy in MR	☐**New Rx given to pt Copy in MR	☐**New Rx given to pt Copy in MR

∞Pre-Op Nurse Signature

* Complete Medication Information Unknown by pt. = CMI Unk

¥ is PACU Nurse Signature

** ☒Check box if pt./cg instructed on medication usa, common side effect, and aftercare upon discharge.

∞ *☐CMI Unk ☐¥ ☐Copy of med list given to pt. on DC.	∞ *☐CMI Unk ☐¥ ☐Copy of med list given to pt. on DC	∞ *☐CMI Unk ☐¥ ☐Copy of med list given to pt. on DC	∞ *☐CMI Unk ☐¥ ☐Copy of med list given to pt. on DC

******** Contact your prescribing physician for questions regarding any medications listed on this page********

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

PATIENT LABEL

PATIENT LABEL

PATIENT LABEL

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JS591

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VVSC Surgical/Procedural Safety Checklist

Note: Patient is patient himself/herself or legal representative or surrogate	Pre-Op	OR	PACU
1. Ensure a clean and sanitary environment for each patient.	S	CM	CM
2. Patient identified as per VVSC policy & ID Band is on patient	S	CM	CM
3. Allergies/ adverse reactions verified and stated on front of chart	S	CM	CM
4. Surgery/Procedure Consent: Operative Procedure & site verified with patient	S	CM	
a. Patient's Signature	S	CM	
b. Witness Signature	S	CM	
5. Anesthesia Consent:	S	CM	
a. Patient's Signature	S	CM	
b. Anesthesia Provider (Anesthesiologist or MD performing procedure) Signature	S	CM	
6. H & P – to include heart and lung (Noted on Pre-Op checklist form)	S	CM	
7. Pre-Op MD Orders	S	CM	
a. As ordered, pre-op test(s): ☐ Completed, results reviewed and placed in chart ☐ Not present, action taken (See pre-op checklist nurse's note) ☑ N/A	S	CM	
b. Standing Orders to draw blood sugar and /or urine pregnancy test ☑ N/A	S		
c. Actions if blood sugar is out of range. Noted on back of Pre-Op Checklist and in blood sugar result log ☑ N/A	S		
d. Antibiotic as ordered: ☐ Initiated ☐ Completed ☑ N/A	S	CM	
e. *Any special equipment, devices, implants ☐ Yes ☑ N/A	S	CM	
8. Procedure Site: MD marked Operative site ☐ Yes ☑ N/A	S		
9. Pre-Op Anesthesia/Nurse Assessment Form / Medication List	S		
a. Patient Signature	S		
b. Nurse Signature	S		
c. Medication list has dosage, frequency, date last taken. If pt. doesn't know, document	S		
Any G-Codes occurrences? ☑ No ☐ Yes List G-Code_____ **See back of sheet for**	S		
10. IntraOp or Intra Treatment: Ensure a clean and sanitary environment for each patient			
11. Intra Operative briefing before procedure started: *Time-Out* performed per policy, allergy status and other concerns discussed- *difficult airway or aspiration risk or aspiration risk, risk of blood loss if applicable			
12. *Procedure site is marked and visible ☐ N/A			
13. *Relevant images properly labeled and displayed ☐ N/A			
14. *De-briefing after completion of procedure			
a. Name of procedure performed			
b. Sponge, sharp count performed ☒ N/A			
c. Specimens identified and labeled ☒ N/A			
d. *Any equipment problems to be addressed ☒ N/A			
e. *Key concerns for recovery and management of this patient ☒ N/A			

JS592

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

	Pre-	OR	PACU
15. Sterilization Documentation completed/initialed			
16. O. R. Record Complete with out of OR time			
# 10 to #16 completed by			
Any G-Codes occurrences? ☒No ☐Yes List G-Code_____ **See below for references**			
17. Ensure a clean and sanitary environment for each patient			
18. Admit time to PACU			
19. Post Op Orders Noted			
20. Signature of Discharging MD for anesthesia recovery Discharge time on PACU record			
21. Discharge time to home or transfer to hospital noted ☐Yes			
22. Copy of VVSC's prescriptions ☐Yes ☐ N/A			
23. Name of responsible adult pt. discharged to noted on discharge instructions			
24. Phone number of the physician doing surgery or procedure on discharge instructions			
Any G-Codes occurrences? ☐No ☐Yes List G-Code_____ **See below for references**			
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
Nurse Name: **Printed**	Signature:	/ Initials:	
RN Co-sign for LPN: **Printed**	Signature:	/ Initials:	

ALL AREAS MUST BE SIGNED OFF AT THE TIME OF DISCHARGE FROM PACU FOR CHART TO BE COMPLETE First and last name initials signify the nurse has completed the listed responsibility. "O" with initials next to it signifies the nurse assessed the responsibility and completion is needed.*Revisions Additions to this form adopted from AORN Comprehensive Surgical Checklist that incorporated WHO, Joint Commission-Universal Protocol (JC) 2010 National Patient Safety Goals.

Measure Description	G-Code
Patient Burn	**G8908** Patient documented to have received a burn prior to discharge
Patient Fall	**G8910** Patient documented to have experienced a fall within VVSC
Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	**G8912** Patient documented to have received/experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant
Hospital Transfer/Admission	**G8914** Patient documented to have experienced hospital transfer/admission
Prophylactic IV Antibiotic Timing	**G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time.
	G8917 Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time.

NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
SEX: F
DOS: 03/09/17

I consent to the admission to Valley View Surgery Center (VVSC) for my treatment(s) and authorize VVSC, staff, and doctor(s) to provide care. I authorize and direct **DR. TRAVNICEK** to perform the following treatment(s) or any other treatment deemed necessary at the discretion of the physician:

BILATERAL LUMBAR FACET JOINT INJECTIONS WITH THE USE OF FLUOROSCOPIC GUIDANCE

Physicians providing services at VVSC are not agents or employees of VVSC.

I understand I have the right to be informed. My physician has explained the treatment(s) necessary to treat my condition, purpose of the treatment and its associated anticipated benefits, including but not limited material risks, and alternative methods of treatment and its associated anticipated benefits, including but not limited material risks. No guarantee has been given as to the results that may be obtained. I accept the risks of substantial and serious harm, if any, in hopes of obtaining desired beneficial results. I have the right to be informed of the likelihood of success and the problem(s) associated with recuperation and the possible results of non-treatment. I have the right to request/consent to or to refuse any proposed treatment at any time prior to its performance.

I have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation/procedure. I have the right to be informed if any professional relationship to another health care provider or institution that may suggest a conflict of interest exists.

If applicable, I authorize the administration of anesthesia from an anesthesia provider as may be deemed necessary for the treatment.

My signature below authorizes the pathologist to use his/her discretion in disposing of any tissue removed from my person during the treatment(s) described above. I authorize x-rays, photographs, or videotaping for diagnostic or medical education purposes including utilization of medical residents, students, and/or manufacturing representatives.

I authorize to the drawing of a blood sample from my body in the event that an employee or physician of the surgery center has an accidental puncture or mucous membrane (eye, mouth, etc) exposure to my blood or body fluids. The blood samples will be tested for HIV and Hepatitis. No results of any tests done on my blood will be released or shown to any unauthorized person without my written consent.

My signature on this form indicates that I have read and understand the information provided on this form, that the treatment(s) described above has been adequately explained to me by my physician, that I have had the opportunity to ask questions, that I received the information I desire concerning the treatment, and that I consent and authorize to the performance of the treatment(s) upon myself.

I understand and agree that I am solely responsible for maintaining the privacy of my protected health information in the paperwork I received.

I have not eaten or drank since (Date& Time) 22Q ☐Fluid, _____ (am't), ☒Solid 3/8/17 2200
I have a responsible adult to drive me home.

X _____
Patient's Signature or Patient's Representative or Surrogate
Relationship to Patient: ☒Self ☐Other

3/9/17 Date 0910 Time

_____
Signature of person witnessing the patient's or patient's legal representative signature

3/9/17 Date 0910 Time

☒ Verified consent CM/KN Initials of circulator

< SEKERA, JOYCE >

Valley View Surgery Center

Treatment Consent/Authorization

NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

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JS594

Patient Consent for Anesthesia at Valley View Surgery Center

I understand:

I will need anesthesia services for the surgery/procedure to be done today,

- And the amount of anesthesia to be used will depend upon the procedure(s) and my physical condition. Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical/surgical procedure.
- During the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
- Although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are a part of the risks I must consider in deciding to have a procedure. Some of the unusual risks and complications of anesthesia may include but are not limited to allergic or adverse reactions, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/by others, seizures, sore throat, and death.
- A detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to inform me. No guarantees have been made by anyone regarding the anesthesia services which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS:

Patient Initials	
____	☐ **General Anesthesia:** 1. Mask Anesthesia- Gases are passed through a mask which covers the nose and mouth or 2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth or 3. Laryngeal/Mask Anesthesia- Gases are passed through a mask placed behind the tongue which covers the larynx (voice box) or 4. Deep sedation.
____	☐ **Regional Anesthesia** 1. Nerve block-Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.
____	☐ **Monitored Anesthesia Care (MAC)**, Total Intravenous Anesthesia (TIVA) - The anesthesiologist monitors blood pressure, oxygenation, pulse, and mental state and supplements sedation and analgesia as appropriate.
____	☐ **Local Anesthesia** 1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedure site. 2. Topical Anesthesia- Surface anesthesia is produce by direct application of anesthetizing agents on skin or membrane.
JS	☑ **Conscious Sedation by RN** - Involves the use of intravenous medication administered by licensed registered nurses under the direct supervision of the physician performing the surgery/procedure.

DNR ORDERS: I understand that DNR (do not resuscitate) orders will be suspended while I am in the procedure and until I completely recover from the effects of anesthesia.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to the acceptance of anesthesia might be no anesthesia for the procedure.

X _____ 3/9/17 0910
Patient's Signature or Patient's Legal Representative Date Time

_____ 3/9/17 0910
Signature of person witnessing the patient's or patient's legal representative signature Date Time

Valley View Surgery Center

Anesthesia Consent

Patient NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17
AGE: 60
SEX: F

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JS595

Next of Kin/*Pariente Próximo:*

Name/*Nombre:* Carole DiVito (MARISSA FREEMAN) Relationship/*Relacion:* Carole Mother Marissa - Daughter

Address and/or telephone number/*Domicilio o Numero de Telefono:* 702-525-9601

In Case of Emergency, I authorize VVSC to Contact/

En caso de Emergencia, yo autorizo a VVSC contactar a:

Name/*Nombre:* MARISSA FREEMAN Relationship/*Relacion:* daughter

Address and/or telephone number/*Domicilio o Numero de Telefono:* _____

I authorize VVSC staff to discuss my medical care with / *Yo autorizo al personal de VVSC para discutir mi cuidado medico con:*

Name of person(s) / *Nombre de persona (s)* MARISSA FREEMAN/CAROLE DiVITO

Advanced Directive / *Directivas Anticipadas:* (not applicable for patients under 18 years of age / *no es aplicable a pacientes menores de 18 años*)

Information regarding Advanced Directives is included in the Patient Information Packet /
La informacion sobre Directivas Anticipadas esta incluida en su paquete de informacion

____ **I do** have an advanced directive / ***Si tengo*** *una Directiva Avancada:*

- A copy is provided to VVSC: **Yes** **No** / *Se propociona una copia a VVSC:* ***Si*** ***No***
- I understand that it is my responsibility to inform my physicians of my Advance Directive /
  Yo entiendo que es mi responsabilidad informar a mis medicos de mi Directiva Anticipada.

✓ **I do not** have an advanced directive / ***Yo no*** *tengo una Directiva Anticipada*

Acknowledgement of receipt of Patient Information Packet/*Reconocimiento de paquete de informacion de paciente:*

As required by CMS (federal regulation), written and verbal notice regarding Patients Rights and Responsibilities, Advance Directives and the facility's corresponding Policy, and a list of VVSC business owners is given to patients. Signature below acknowledges receipt of the written and verbal notice. / *Segun los requisitos de CMS (regulacion federal), por escrito y la notificacion n verbal sobre los Derechos y Responsabilidades de los Pacientes, directivas anticipadas y la politica correspondiente de la instalacion, y una lista de los dueños del negocio de VVSC se da a los pacientes. La firma debajo confirma que la a recibio por escrito y verbal.*

☐ Received this date / *Recibido esta fecha*

☐ Received with previous date of service / *Recibido con la fecha anterior del servicio*

X Joyce Sekera Date / *Fecha:* 3-9-17

Patient/Patient Representative signature (if other than patient: relationship:_____)

Valley View Surgery Center
Patient Acknowledgements

M: FORMS Registration forms Next of Kin English Spanish.docx

Patient
NAME: SEKERA, JOYCE P
ACT#: 153654
DOB: 03/22/56 AGE: 60
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

JS596

WLVSCdba Valley View Surg Ct
1330 S Valley View Blvd
Las Vegas, NV 89102-1865
(702)675-4600

WLVSCdba Valley View Surg Ctr
Dept N905, P.O.Box 30102
Salt Lake City, UT 84130

153654 083

20-1898649 113017 113017

SEKERA, JOYCE P

7840 NESTING PINE PL
Las Vegas NV 89143

03221956 F 01

SEKERA, JOYCE P
7840 NESTING PINE PL
Las Vegas, NV 89143

490 AMBUL SURG	64635	113017	1	2,800.00	
490 AMBUL SURG	64635	113017	1	2,800.00	

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LIEN PAYER Y Y

SEKERA, JOYCE P 13 00000000000 DOI:11/04/2016

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0

1356467831
TRAVNICEK KATHERINE

1356467831
TRAVNICEK KATHERINE

ATTY; KEITH GALLIHER
1850 E. SAHARA #107

Las Vegas, NV 89104

WLVSCdba Valley View Surg Ct
1330 S Valley View Blvd
Las Vegas, NV 89102-1865
(702)675-4600

VLVSCdba Valley View Surg Ctr
ot N905, P.O.Box 30102
lt Lake City, UT 84130

153654 083

20-1898649 050817 050817

SEKERA, JOYCE P | 7840 NESTING PINE PL | Las Vegas | NV 89143

03221956 F 01

SEKERA, JOYCE P
7840 NESTING PINE PL
Las Vegas, NV 89143

490	AMBUL SURG	64493	050817	1	2,472.37	
490	AMBUL SURG	64493	050817	1	2,472.37	

0001 PAGE 1 OF 1 CREATION DATE 05/24/17 4,944.74 0.00

1669585964

LIEN PAYER Y Y

SEKERA, JOYCE P 18 00000000000 DOI:11/04/2016
,
,

APPROVED N/A

JS598

M47817 M545
0
M545

1356467831
TRAVNICEK KATHERINE
1356467831
TRAVNICEK KATHERINE

ATTY; KEITH GALLIHER
1850 E. SAHARA #107

Las Vegas, NV 89104

WLVSCdba Valley View Surg Ct
1330 S Valley View Blvd
Las Vegas, NV 89102-1865
(702)675-4600

WLVSCdba Valley View Surg Ct
pt N905, P.O.Box 30102
Salt Lake City, UT 84130

3a PAT. CNTL #: 153654
b. MED. REC. #: 153654
4 TYPE OF BILL: 0831
5 FED. TAX NO.: 20-1898649
6 STATEMENT COVERS PERIOD FROM: 030917 THROUGH: 030917

8 PATIENT NAME: SEKERA, JOYCE P
9 PATIENT ADDRESS: 7840 NESTING PINE PL, Las Vegas NV 89143

10 BIRTHDATE: 03221956
11 SEX: F
17 STAT: 01

SEKERA, JOYCE P
7840 NESTING PINE PL
Las Vegas, NV 89143

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
490	AMBUL SURG	64493RT	030917	1	2,472.37	
490	AMBUL SURG	64493LT	030917	1	2,472.37	
0001	PAGE 1 OF 1	CREATION DATE	03/17/17		4,944.74	0.00

50 PAYER NAME: LIEN PAYER
52 REL. INFO: Y
53 ASG. BEN.: Y
55 EST. AMOUNT DUE: 4,944.74
56 NPI: 1669585964

58 INSURED'S NAME: SEKERA, JOYCE P
59 P. REL: 18
60 INSURED'S UNIQUE ID: 00000000000
61 GROUP NAME: DOI:11/04/2016

63 TREATMENT AUTHORIZATION CODES: APPROVED
65 EMPLOYER NAME: N/A

JS599

67 DX: M47817 M1288 M545
0

76 ATTENDING NPI: 1356467831
LAST: TRAVNICEK FIRST: KATHERINE
77 OPERATING NPI: 1356467831
LAST: TRAVNICEK FIRST: KATHERINE

80 REMARKS: ATTY; KEITH GALLIHER
1850 E. SAHARA #107
Las Vegas, NV 89104

Patient Ledger History - Detail

WLVSCdba Valley View Surg Ctr
1330 S Valley View Blvd
Las Vegas, NV 89102
(702) 675-4600

JOYCE SEKERA (153654)
7840 NESTING PINE PL

Las Vegas, NV 89143
(702) 467-5457

Billing message: No message assigned

Trans date	Post date	Facility	Proc/jnl qc	Procedure / journal description	ICD-10 DX1	ICD-9 DX1	Provider	Amount	Due
7/22/2015	7/27/2015	WLVS	45378	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPL		V76.51	WAHID	4,788.86	0.00
8/20/2015	8/23/2015	WLVS	INS PM	INS PAYMENT			WAHID	481.68	0.00
8/20/2015	8/23/2015	WLVS	ADDTL	ADDTL CONTRACTUAL WRITE OFF			WAHID	4,307.18	0.00
3/9/2017	3/17/2017	WLVS	64493	INJ, LUMBARorSACRAL, DIAG OR THERA AGENT	M47.817		TRAV	2,472.37	2,472.37
3/9/2017	3/17/2017	WLVS	64493	INJ, LUMBARorSACRAL, DIAG OR THERA AGENT	M47.817		TRAV	2,472.37	2,472.37

Totals:				
	Charge:	9,733.60		
	Payment:	481.68	CP:	0.00
	Writeoff:	4,307.18	CW:	0.00
	Debit:	0.00	CD:	0.00
	Patient bal:	0		
	Account bal:	4944.74		

JS600

627

NAME: SEKERA, JOYCE P
ACT#: 153654 AGE: 60
DOB: 03/22/56
DR: TRAVNICEK, KATHERINE M.D.
DOS: 03/09/17 SEX: F

Patient Ledger History - Detail

WLVSCdba Valley View Surg Ctr
1330 S Valley View Blvd
Las Vegas, NV 89102
(702) 675-4600

JOYCE SEKERA (153654)
7840 NESTING PINE PL

Las Vegas, NV 89143
(702) 467-5457

Billing message: No message assigned

Trans date	Post date	Facility	Proc/jnl qc	Procedure / journal description	ICD-10 DX1	ICD-9 DX1	Provider	Amount	Due
11/30/2017	12/6/2017	WLVS	64635	DESTRUCTION PARAVERTEBRAL FACET JOINT I	M47.817		TRAV	2,800.00	2,800.00
11/30/2017	12/6/2017	WLVS	64635	DESTRUCTION PARAVERTEBRAL FACET JOINT I	M47.817		TRAV	2,800.00	2,800.00

Totals:				
Charge:	5,600.00			
Payment:	0.00	CP:		0.00
Writeoff:	0.00	CW:		0.00
Debit:	0.00	CD:		0.00
Patient bal:	0			
Account bal:	15489.48			

JS601

STEINBERG DIAGNOSTIC MEDICAL IMAGING CENTERS
Phone: (702) 732-6000 www.sdmi-lv.com Fax: (702) 732-6071

Patient: **Joyce P Sekera**
SDMI #: **790179.0**
Pt. DOB: **03/22/1956**
Pt. Sex: **Female**
Date of Service: **12/21/16**
SDMI Location: **CH**

Physician: **Jordan Webber DC**
Dr. Fax: **(702) 463-9772**
Dr. Phone: **(702) 463-9508**
Dr. Addr.: **7810 W Ann Rd Ste 110 Las Vegas, NV 89149**
Cc:
Cc:

MRI CERVICAL SPINE WITHOUT CONTRAST

CLINICAL HISTORY:

Neck pain and bilateral arm numbness, pain, weakness

TECHNIQUE:

T1 sagittal, T2 sagittal and axial T2 images were obtained. 117 images.

COMPARISON:

None

FINDINGS:

There is mild dextrocurvature centered at C6-7. There is straightening of the cervical lordosis. Vertebral bodies are normal in alignment. Vertebral body heights are maintained. Bone marrow signal is normal. Spinal cord is normal in signal. The paravertebral soft tissues appear unremarkable. The intervertebral discs throughout the cervical spine are desiccated without significant loss of height.

C2-3: No disc bulge, spinal canal or neuroforaminal stenosis.

C3-4: No disc bulge, spinal canal or neuroforaminal stenosis. Mild bilateral facet hypertrophy.

C4-5: No disc bulge, spinal canal or neuroforaminal stenosis. Mild left uncovertebral arthropathy. Mild bilateral facet hypertrophy.

C5-6: Mild broad disc protrusion. Spinal canal AP diameter of 12 mm. Bilateral facet hypertrophy. Bilateral uncovertebral arthropathy. Mild left greater than right neuroforaminal stenosis.

C6-7: Mild broad disc protrusion. Spinal canal AP diameter of 10 mm. No significant neuroforaminal stenosis.

C7-T1: No disc bulge, spinal canal or neuroforaminal stenosis.

IMPRESSION:

Mild multilevel degeneration. Mild neuroforaminal stenosis at C5-C6. No spinal canal stenosis throughout. Mild dextrocurvature. Straightening of the cervical lordosis which may be seen with muscle spasm.

Patient Name: **Joyce P Sekera**

Interpreted by: Sarah Kym MD 12/22/2016 8:20 AM

Electronically approved by: Sarah Kym MD Date: 12/22/16 10:47

STEINBERG DIAGNOSTIC MEDICAL IMAGING CENTERS
Phone: (702) 732-6000 www.sdmi-lv.com Fax: (702) 732-6071

Patient: **Joyce P Sekera**
SDMI #: **790179.0**
Pt. DOB: **03/22/1956**
Pt. Sex: **Female**
Date of Service: **12/21/16**
SDMI Location: **CH**

Physician: **Jordan Webber DC**
Dr. Fax: **(702) 463-9772**
Dr. Phone: **(702) 463-9508**
Dr. Addr.: **7810 W Ann Rd Ste 110 Las Vegas, NV 89149**
Cc:
Cc:

MRI LUMBAR SPINE WITHOUT IV CONTRAST

CLINICAL HISTORY:

Lower back pain secondary to fall 2011 416. Bilateral arm and leg pain and numbness as well as weakness.

TECHNIQUE:

Multiplanar imaging is performed without IV contrast. 108 images.

FINDINGS:

The conus medullaris is in normal position with normal signal. Normal lumbar vertebral body height, signal and alignment with discogenic endplate changes at L2, L3, minimally at L4 as well as at L5. Disc desiccation throughout the lumbar spine with normal disc space height.

At T12-L1, no disc bulge or canal stenosis. No neural foraminal narrowing.

At L1-2, mild disc bulge without canal stenosis. AP dimension of the canal at this level 12 mm. No neural foraminal narrowing.

At L2-3, minimal spondylosis and disc bulge with AP dimension of the canal at this level 12 mm without canal stenosis. No neural foraminal narrowing.

At L3-4, mild disc bulge with AP dimension of the canal at this level 11 mm without canal stenosis. No neural foraminal narrowing. Mild facet and ligamentum flavum hypertrophy bilaterally.

At L4-5, left paracentral disc bulge with annular fissuring. AP dimension of the canal at this level 11 mm without canal stenosis. Facet and ligamentum flavum hypertrophy bilaterally. No neural foraminal encroachment.

At L5-S1, central disc bulge with facet hypertrophy bilaterally. AP dimension of the canal at this level 10 mm without canal stenosis. No neural foraminal narrowing noted. There is note made of a synovial cyst measuring 8 mm extending posteriorly of the left facet joint into the paraspinous musculature without neural impingement.

IMPRESSION:

Multilevel lumbar degenerative disc disease with disc bulges extending from L1-2 through L5-S1. Annular fissuring at L4-5. No canal stenosis or neural foraminal narrowing at any level. There is note made of facet and ligamentum flavum hypertrophy at multiple levels.

Patient Name: Joyce P Sekera

Interpreted by: Saul Ruben M.D. 12/22/2016 8:07 AM

Electronically approved by: Saul Ruben, M.D. Date: 12/22/16 08:41

JS605

Patient: **Joyce P Sekera**
SDMI #: **790179.0**
Pt. DOB: **03/22/1956**
Pt. Sex: **Female**
Date of Service: **12/16/16**
SDMI Location: **CH**

Physician: **Russell Shah**
Dr. Fax: **(702) 641-4600**
Dr. Phone: **(702) 644-0500**
Dr. Addr.: **2628 W Charleston Blvd Las Vegas, NV 89102**
Cc:
Cc:

MRI BRAIN

CLINICAL HISTORY:
Headaches. Dizziness. Fall November 4, 2016

TECHNIQUE:
Sagittal T1, Axial T2, Axial FLAIR, coronal FLAIR

COMPARISON:
None.

FINDINGS:
Brain normal for age. No significant atrophy or small vessel ischemic change. No mass. No infarct. Flow voids patent. Sinuses clear. No hemorrhage.

IMPRESSION:
Brain normal for age

MAGNETIC RESONANCE ANGIOGRAM OF THE BRAIN

CLINICAL HISTORY:
Headaches fall dizziness

TECHNIQUE:
2D/3DTime of flight

FINDINGS:
Signal strength symmetrical. No focal/ central stenosis. No measurable aneurysm

IMPRESSION:
No significant abnormality identified on magnetic resonance angiogram of the brain

Patient Name: **Joyce P Sekera**

Interpreted by: David Browne M.D. 12/16/2016 3:37 PM

Electronically approved by: David Browne, M.D. Date: 12/16/16 19:23

Steinberg Diagnostic Medical Imaging

Account Number: **790179.0**

Guarantor: **Joyce P Sekera**

Account Financial Ledger

Posted	Provider	Voucher	Name	Description	Amount	Balance
12/27/16	28		Sekera, Joyce P	Adj - HPN Capitated Services	-350.00	0.00
12/27/16	41		Sekera, Joyce P	Adj - HPN Capitated Services	-350.00	350.00
12/27/16	28	4809997	Sekera, Joyce P	Mri Lumbar Spine ; Without Contrast (72148, 12/21/16)	350.00	700.00
12/27/16	41	4809996	Sekera, Joyce P	Mri Cervical Spine ; Without Cntrst (72141, 12/21/16)	350.00	350.00
12/22/16	10		Sekera, Joyce P	Adj - HPN Capitated Services	-350.00	0.00
12/22/16	10		Sekera, Joyce P	Adj - HPN Capitated Services	-350.00	350.00
12/22/16	10	4803395	Sekera, Joyce P	Mr Angio Head Without (70544, 12/16/16)	350.00	700.00
12/22/16	10	4803395	Sekera, Joyce P	Mri Brain Without Contrast (70551, 12/16/16)	350.00	350.00

JS608

CERTIFICATE OF CUSTODIAN OF RECORDS
TO ACCOMPANY COPIES OF RECORDS

NOW COMES Miriam Gonzalez, who declares as follows:

1. That the declarant is the receptionist *(position or title)* of DISC *(name of employer)* and in his or her capacity as receptionist *(position or title)* is a custodian of the records of DISC *(name of employer)*.

2. That DISC *(name of employer)* is licensed to do business as a Physician in the State of Nevada.

3. That on the 1 day of the month of December of the year 2017, the declarant was sent an authorization requesting the production of records pertaining to Jackie Sekera.

4. That the declarant has examined the original of those records and has made or caused to be made a true and exact copy of them and that the reproduction of them attached hereto is true and complete.

5. That the original of those records was made at or near the time of the act, event, condition, opinion or diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of the declarant or DISC *(name of employer)*.

Pursuant to NRS § 53.045, I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

By: Miriam Gonzalez
Name: Gonzalez, Miriam
Title: Custodian of Records

JS609

DISC
Desert Institute of Spine Care

Sekera, Joyce

61 Y old Female, DOB: 03/22/1956
Account Number: 10429
7840 Nesting Pine Place, LAS VEGAS, NV-89143
Home: 702-467-5457
Guarantor: Sekera, Joyce Insurance: THE GALLIHER LAW FIRM Payer ID: PAPER
Referring: LAW FIRM THE GALLIHER
Appointment Facility: Desert Institute of Spine Care

10/05/2017 Progress Notes: Andrew M. Cash, MD

Current Medications
Taking
- Metformin HCl

Past Medical History
Diabetes

Surgical History
Denies Past Surgical History

Family History
Family Member: diagnosed with Diabetes

Social History
Tobacco Use:
Tobacco Use/Smoking
Smoking Status: *current smoker*
How many cigarettes a day do you smoke? *5 or less*
Occupational:
Occupation History: The patient is currently working. Her duties include walking and sitting.
Drugs/Alcohol:
Do you drink alcohol?: No.
Do you smoke marijuana?: Denies.
Miscellaneous:
Marital status: single.
Children: has 1 daughter.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Denies Past Hospitalization

Review of Systems
General/Constitutional:
Chills denies. Fatigue admits. Fever denies. Sweats admits. Weight gain admits. Weight loss denies.
ENT:
Hoarseness denies. Visual changes admits. Difficulty

Reason for Appointment
1. Neck and back

History of Present Illness
Todays Visit:
The patient is a 61 year old female who was involved in a slip and fall on 11/4/2016. The patient was walking through The Venetian Hotel when she slipped on a liquid that was spilled on the floor. She reports that both legs flew up in front of her and she landed on her back. Immediately after the fall she felt pain in her left elbow, neck, and back. She states that her pain is constant throughout the day. On average her neck pain is 6/10, 7/10 at its worst. On average her back pain is 5/10, 7/10 at its worst. She complains of numbness, tingling, weakness, and pain in her upper and lower extremities. The pain affects her ability to sleep and perform physical activity.
Current Treatment:
Pain Management, Chiropractic.
Prior Injuries::
None.

Vital Signs
Ht 5 ft 6 in, Wt 180 lbs, BMI 29.05 Index, RR 16 /min, Taken by aj.

Examination
General Examination:
GENERAL APPEARANCE: well nourished and hydrated.
EYES/ENT: Pupil: Bilateral equal and direct reaction to normal light, normal conjuctiva and lids.
ENT inspection shows no scars, lesions or foreign bodies. Lips, teeth, and gums appear normal.
NECK, THYROID: No masses, symmetrical, no enlargement of thyroid.
NEUROLOGIC: Cranial nerves:
II Optic: Bilateral visual acuity
III Oculomotor: Normal pupillary constriction.
IV Trochlear: Normal bilateral.
V Trigeminal: Normal bilateral.
VI Abducens: Normal bilateral.
VII Facial: Normal bilateral.
VIII Acoustic: Normal hearing bilateral.

swallowing denies. Stuffed nose or sinuses **admits**. Sore throat denies.
Respiratory:
Breathing problems denies. Frequent coughing **admits**. Blood in sputum denies. Sputum production denies.
Cardiovascular:
Chest pain denies. Irregular heartbeat denies.
Gastrointestinal:
Hemorrhoids denies. Ulcers denies. Painful bowel movements denies. Black stool denies. Abdominal pain denies. Blood in stool denies. Change in bowel habits denies. Diarrhea denies. Heartburn **admits**. Nausea denies. Vomiting denies.
Genitourinary:
Loss of urine denies. Blood in urine denies. Frequent urination denies. Kidney stones denies. Painful urination denies.
Musculoskeletal:
Neck pain **admits**. Low back pain **admits**. Pain down the legs **admits**. Pain down the arms **admits**. Hip pain denies .
Skin:
Easy bruising denies. Easy bleeding denies. Lumps under the skin denies. Rash denies.
Neurologic:
Blackouts denies. Slurred Speech denies. Fainting denies. Headache **admits**. Loss of strength **admits**. Seizures denies. Stroke denies. Tingling/Numbness **admits**. Tremor denies.
Psychiatric:
Tension denies. Memory loss **admits**. Anxiety denies. Depressed mood denies. Difficulty sleeping **admits**.

The patient's handwritten intake forms and information has been reviewed, documented, verified, & reconciled, through oral confirmation, and the type written dictation incorporated all information, representing the complete and corroborated historical and current account.

NEUROPSYCHIATRIC: Approprite judgement and insight, alert and oriented x3.
Associations- Intact.
Thought Processes/Cognitive Function- Approprite fund of knowledge.
Imaging Studies:
Results: Lumbar disc protrusion(s).
Time was spent with the patient reviewing imaging in the office today offering full explanations of the pathology therein, as well as different treatment options that could be provided for such pathological findings. As appropriate, the patient was shown illustrations and models for a better understanding of the condition as well as given literature. I reviewed with the patient the records, images, and diagnostic/therapeutic protocol in detail and to their satisfaction.
Medical Records:
Records reviewed from:

Dr.Travnicek and Steinberg

Spine:

Lumbar:

There is painful extension, facet tenderness, and concordant facet loading.
There is bilateral paraspinal musculature pain and tenderness.
Muscle strength is 5/5 bilaterally.
Deep tendon reflexes are symmetrical.
Light touch sensation is intact.
The hip exam is unremarkable.
The sacroiliac joint exam is unremarkable

Assessments
1. Facet syndrome - M12.88 (Primary)

Treatment
1. Facet syndrome
Referral To:Pain Medicine
Reason:lumbar RFA

Diagnostic Imaging
Imaging: CRV MINUMUM 4 VIEWS
Imaging: RADEX SPI LUMBOSAC MINIMUM 4 VIEWS

Disability/Prognosis/Causation
DISABILITY:
Lumbar restrictions: No repetitive bending, twisting, stooping crawling, climbing, squatting, or lifting more than 10 pounds

frequently or 20 pounds occasionally.
PROGNOSIS:
Prognosis: Diminished without the recommended treatment..
Prognosis: The patient may experience future exacerbations as there is structural compromise to the spine and will require future treatment.
.
CAUSATION:
In my opinion the patient's symptoms which we are evaluating are directly related to the above mentioned accident(s). This opinion is based on patient's history, physical exam, diagnostic studies, and medical records provided. I welcome the opportunity to review any and all medical records regarding past or present treatment of the patient which could possibly reinforce or otherwise affect the above opinions. Final causation requires review of records .
Opioid Risk:
The risks of opioid medications were explained to the patient. The patient understands and agrees to use these medications only as prescribed. The patient agrees to obtain pain medications from this practice only. We have fully discussed the potential side effects of the medication with the patient. These include, but are not limited to, constipation, drowsiness, addiction, nausea, vomiting, impaired judgment and the risk of fatal overdose if not taken as prescribed. We have warned the patient that sharing medications is a felony. We have warned the patient against driving while taking sedating medications.

Procedure Codes
72050 X-RAY EXAM OF NECK SPINE
72110 X-RAY EXAM OF LOWER SPINE

Follow Up
4 Weeks

Electronically signed by Andrew Cash MD on 10/06/2017 at 09:49 AM PDT

Sign off status: Completed

Desert Institute of Spine Care
9339 W SUNSET RD

LAS VEGAS, NV 89148-4849
Tel: 702-630-3472
Fax: 702-946-5115

Patient: Sekera, Joyce DOB: 03/22/1956 Progress Note: Andrew M. Cash, MD 10/05/2017

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

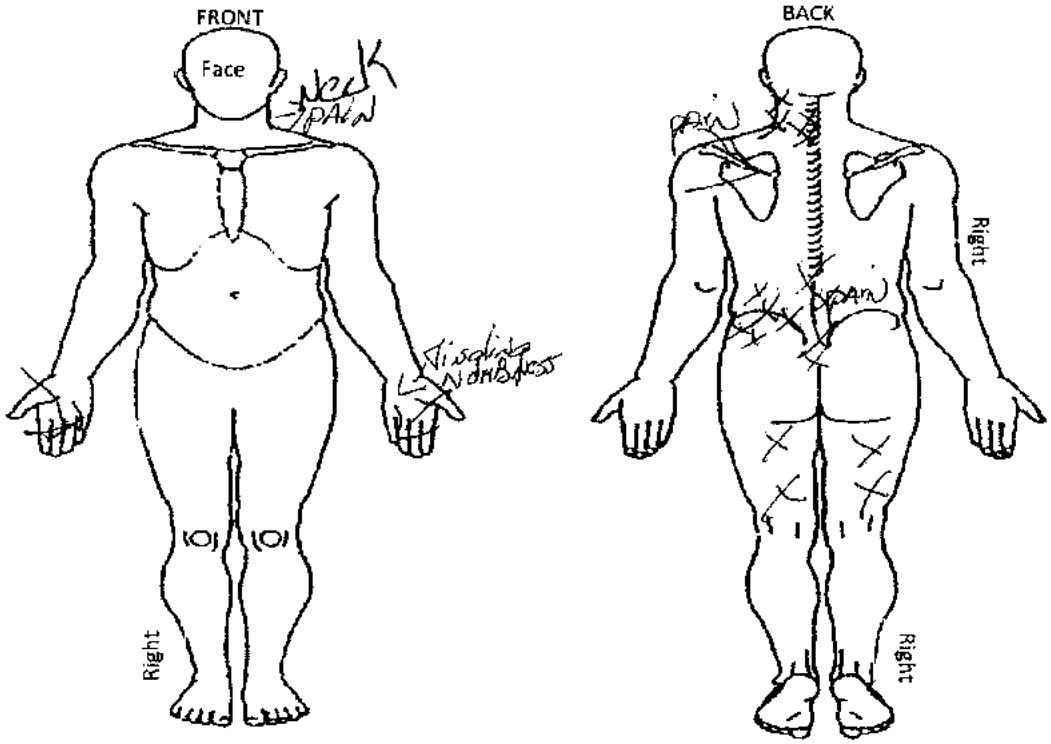
JS613

DISC Phone: 702-630-3472
Fax: 702-946-5115

Height: 5'6 Weight: _____

What is your chief complaint? Lower Back/Neck/Arm pain/Leg pain

Mark on the body diagram below where you are experiencing any pain, numbness or tingling. Please try to stay within the body lines. Pay attention to front/back and right/left:



IF YOUR INJURY RESULTED FROM **MOTOR VEHICLE ACCIDENT**: Date of accident/injury: __/__/__
How did impact happen? Please provide **ALL** details. -

IF YOUR INJURY RESULTED FROM A **SLIP, TRIP or FALL**: Date of accident/injury: 11/4/2016
Describe what happened… Be specific. What did you slip/trip on? What body parts did you land on? Did you collide with anything during the fall? I slipped on Liquid that was on the Floor at The Venetian & I fell Back. I just Remember this the Huge very hard My Feet were up in front of me I fell on my left Side elbow & Back.

OTHER: _____

DISC Phone: 702-630-3472
Fax: 702-946-5115

CURRENT TESTS & TREATMENTS

Have you had any of the following tests for your **CURRENT PROBLEM?**

TEST:	BODY PART(S):	DATE:
MRI	BRAIN, LUMBAR, CERVICAL, NECK	
CT SCAN		
X-RAY	LEFT ARM	
OTHER		

NON-OPERATIVE TREATMENTS

Have you had any of the following non-operative treatments for your **CURRENT PROBLEM?**

TREATMENT:	DOCTOR:	BODY PART(S):	HOW LONG:
PHYSICAL THERAPY	DR WEBBER	BACK, LEGS, ARMS	3MO
CHIROPRACTIC CARE	DR WEBBER		
OTHER			

PAIN MANAGEMENT

Have you had any pain management treatment for your **CURRENT PROBLEM?**

NAME:	LAST DATE:	TYPE:
DOCTOR TREVERACK		
INJECTION(S) DR TREVERACK		

MEDICATIONS

Please list all medications you are **CURRENTLY** taking.

NAME:	DOSAGE:	FREQUENCY:	REASON:
METFORMIN	1 DAILY		

TREATING DOCTORS

Please list all doctors treating you for your **CURRENT PROBLEM.**

DOCTOR NAME:	LAST DATE:	TREATMENT TYPE:
DR SHAH		

DISC Phone: 702-630-3472
Fax: 702-946-5115

OTHER THAN THE INJURIES YOU ARE BEING SEEN FOR TODAY, HAVE YOU EVER HAD A SIGNIFICANT INJURY/PROBLEM TO ANY OF THE SAME BODY PARTS?

HAVE YOU EVER BEEN IN A PREVIOUS CAR ACCIDENT, SLIP AND FALL OR OTHER ACCIDENT / INJURY INVOLVING THE SPINE? IF SO PLEASE EXPLAIN:

NO

PREVIOUS TESTS & TREATMENTS

Have you had any of the following tests for a **PREVIOUS PROBLEM?**

TEST:	BODY PART(S):	DATE:	HOW IT HAPPENED:
MRI			
CT SCAN			
X-RAY			
OTHER			

NON-OPERATIVE TREATMENTS

Have you had any of the following non-operative treatments for a **PREVIOUS PROBLEM?**

TREATMENT:	DOCTOR:	BODY PART(S):	HOW LONG:
PHYSICAL THERAPY			
CHIROPRACTIC CARE			

PAIN MANAGEMENT

Have you had any pain management treatment for a **PREVIOUS PROBLEM?**

NAME:	LAST DATE:	TYPE:
DOCTOR		
INJECTION(S)		

DISC
Phone: 702-630-3472
Fax: 702-946-5115

NECK PAIN: Only complete this page if you have neck pain.
PLEASE CIRCLE THE NUMBER THAT MOST APPLIES TO YOU IN ALL SECTIONS.

SECTION 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes & goes & is moderate.
3. The pain is moderate & does not vary much.
4. The pain is severe but comes & goes.
5. The pain is severe & does not vary much.

SECTION 2: Personal Care (Washing, Dressing etc.)
0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow & careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4: Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all because of neck pain.

SECTION 5: Headache
0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come in-frequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time

SECTION 6: Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

SECTION 7: Work
0. I can do as much work as I want to.
1. I can only do my usual work but no more.
2. I can do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

SECTION 8: Driving
0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

SECTION 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10: Recreation
0. I am able to engage in all recreational activities with no pain in my neck at all.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
3. I am able to engage in only a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

Sexual Activity
Please place a check mark next to the statement that applies to you:
____ I am able to perform sexual activity when I want with no pain
____ I can perform sexual activity with little pain
____ I can perform sexual activity but it increases my pain level
____ I can hardly perform sexual activity because of my pain
____ I cannot perform any sexual activity because of my pain

NECK, ARM OR SHOULDER PAIN:
Please circle your pain level 0 = No Pain, 10 = Worst possible pain

What is your AVERAGE: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What is your WORST: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

What makes pain feel worse? (Circle all that apply) Work, sit, stand, walk, lie down, daily activity, _____

How much did these treatments help your pain? Physical therapy ___% Chiropractic ___% Injections ___% Surgery ___%

If you have neck AND arm pain, which is worse (or they about equal)? Neck - more

JS617

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BACK PAIN: Only complete this page if you have back pain.

PLEASE CIRCLE THE NUMBER THAT MOST APPLIES TO YOU IN ALL 10 SECTIONS.

SECTION 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes & goes & is moderate.
3. The pain is moderate & does not vary much.
4. The pain is severe but comes & goes.
5. The pain is severe & does not vary much.

SECTION 2: Personal Care (Washing, Dressing etc.)
0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow & careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4: Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain
4. I cannot walk more than 1/4 mile without increasing pain
5. I cannot walk at all without increasing pain.

SECTION 5: Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Sexual Activity
Please place a check mark next to the statement that applies to you:
___ I am able to perform sexual activity when I want with no pain
___ I can perform sexual activity with little pain
___ I can perform sexual activity but it increases my pain level
___ I can hardly perform sexual activity because of my pain
___ I cannot perform any sexual activity because of my pain

SECTION 6: Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

SECTION 7: Social life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, for example, dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of pain

SECTION 8: Driving
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternate forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

SECTION 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10: Recreation
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

BACK OR LEG PAIN:

Please complete the following: **Please circle your pain level 0 = No Pain, 10 = Worst possible pain**

What is your AVERAGE: No Pain 1 2 3 4 **5** 6 7 8 9 10 Worst Pain

What is your WORST: No Pain 1 2 3 4 5 6 **7** 8 9 10 Worst Pain

What makes pain feel worse? (Circle all that apply) Work, sit, stand, walk, lie down, daily activity, _____

How much did these treatments help your **BACK** pain? Physical therapy 40% Chiropractic 10% Injections 0 % Surgery 0 %

If you have back AND leg pain, which is worse (or they about equal) BACK

JS618

645

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Review of Systems- Have you been experiencing any of the following in the last month? Circle all that apply

General: Fever, Chills, Sweats, Fatigue, Weight Gain, Weight Loss.

Gastrointestinal: Nausea, Vomiting, Change in bowel habits, Blood in Stool, Black Stool, Hemorrhoids, Diarrhea, Ulcer, Heartburn, Painful bowel movements, Abdominal pain.

Neurologic: Weakness, Numbness, Fainting, Seizure, Stroke, Blackout, Headache, Tremors, Slurred Speech.

Genitourinary: Loss of urine, Frequent Urination, Painful Urination, Blood in urine, Kidney Stones.

Psychiatric: Depression, Anxiety, Tension, Memory loss, Difficulty sleeping.

Musculoskeletal: Low back pain, Neck pain, Hip Pain, Pain down Legs, Pain down Arms.

Skin: Rashes, lumps under the skin, easy bruising, easy bleeding.

Eyes/Ears/Nose/Throat/Mouth: Sore throat, difficulty swallowing, stuffed nose or sinuses, hoarseness, visual changes.

Cardiovascular: Chest pain, skipped or irregular heartbeats.

Respiratory: Trouble breathing, frequent coughing, production of sputum, blood in sputum.

ALLERGIES: Please list the allergy below along with the reaction.

Allergy:	**Reaction:**
N/A	

GENERAL HISTORY

	YES	NO	EXPLAIN
DO YOU SMOKE	✓		Friday
DO YOU DRINK ALCHOL		✓	
DO YOU USE ILLEGAL SUBSTANCES		✓	
ARE YOU MARRIED		✓	
DO YOU HAVE CHILDREN	✓		1 daughter
DO YOU USE RECREATIONAL SUBSTANCES		✓	

OCCUPATIONAL HISTORY: Describe your **PHYSICAL DUTIES** at work with focus on your MOST PHYSICAL DEMANDS (how much weight do you lift, how often and how long) and how long do you sit, stand, and what is are the most bothersome or painful activities:

walking, sitting (everything I can't do)

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MEDICAL HISTORY: Please indicate if **YOU** have had any of the conditions listed below:

CONDITION		EXPLAIN
DIABETES	✓	
HIGH BLOOD PRESSURE	NO	
KIDNEY DISEASE	NO	
CANCER	NO	
OTHER	NO	

FAMILY HISTORY: Please indicate if a **BLOOD RELATIVE** has a history of the following:

CONDITION		EXPLAIN
DIABETES	✓	Dad
HIGH BLOOD PRESSURE	NO	
KIDNEY DISEASE	NO	
CANCER	NO	
OTHER		

PAST SURGICAL HISTORY: Please mark all surgical procedures and implantable devices you have had:

ABDOMINAL	CERVICAL	METAL IMPLANT
APPENDIX	LUMBAR	PAIN PUMP
GALLBLADDER	THORACIC	ROD(S)
HERNIA	SHOULDER	SHRAPNEL OR BULLET
AORTIC ANEURYSM	DEFIBRILLATOR	SCREW(S)
CAROTID	PACEMAKER	PLATE(S)
BYPASS	VALVE	OTHER
VEIN STRIPPING	THYROID	I HAVE HAD NO SURGERIES

N/A

JS620

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Fax: 702-946-5115

Financial Policy, Assignment of Benefits, HIPAA, and Medication Policy Signature Form

I, the undersigned patient, assign payment (s) directly to Desert Institute of Spine Care or DISC; Dr. Andrew Cash. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance. Certain tests may be ordered by Dr. Cash such as X-rays and or toxicology screens. I agree to be financially responsible for these services should they be considered "non-covered", "out of network" or not medically indicated by my insurance company. As a courtesy referrals will be sent out according to the physicians recommendations. it is my responsibility to verify that these providers are within my insurance network. I understand that DISC is not responsible for charges incurred or treatment performed on an out of network basis. If my treatment is involved in a lien, it is my responsibility to notify the office if there are any changes in legal representation. If my treatment is involved with a work related injury and Dr. Cash is to file Workman's Compensation claims on my behalf, I authorize the doctors and staff to discuss plan of treatment, care and appointment information with claims payers and/or case workers. There will be a charge of **$50.00 for All NO Show Appointments or cancellations less than 24 hours prior to the scheduled appointment time.** There will be a charge **of $50.00 for all returned checks**. If my account becomes delinquent and referred to a collection agency, I will be responsible for the costs of collection and/or legal fees. There will be an interest charge of **$50.00** for all delinquent payments at time of service. JS **(initial)** I hereby assign Andrew M. Cash MD, their Physician Assistants, and surgical technologists any or all benefits for surgical and medical care. I also authorize release of information to secure payment. A photocopy of this assignment is to be considered as valid as the original. JS **(initial)**

Joyce SeKeRA 10/5/17

Patient name **Patient signature** **Date**

Agreement as to resolution of concerns:

"I", "Patient/Guardian" shall be understood to mean Joyce SeKeRA (patient name). "Physician" Andrew M. Cash M.D. Desert Institute of Spine Care. Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I Joyce SeKeRA (patient name) and/or my representative agree to use American Board of Orthopaedic Surgery (ABOS) board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the ***Clark County Medical Society.*** Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the ***North American Spine Society and American Academy of Orthopaedic Surgeons.*** I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the ***North American Spine Society and American Academy of Orthopaedic Surgeons*** and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members **Clark County Medical Society.** In further consideration for this, Physician agrees to the same stipulations. Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief, in addition to monetary damages.

Patient or responsible party signature — Date: 10/5/17

Physician signature — Effective date of treatment: 10/5/17

JS621

DISC Phone: 702-630-3472
Fax: 702-946-5115

PLEASE CHOOSE ONE:

Insurance only

Primary Insurance Co. Name: _____

Insured Name: _____ Insured DOB: _____ Insured Social Security # _____-_____-_____
Policy Id# _____ Group# _____

Print Name: _____ Signature: _____

I also have an attorney representing me; the attorney information is:

Attorney name: _____ Law Firm: _____

I understand by using my private health insurance, although I have an Attorney, I will be responsible for payment at time of service. And any charges not covered by my insurance.

Signature: _____

Lien Only

I DO NOT have health insurance. Therefore, please bill all of my office visits and or charges directly to the attorney listed below:
Attorney name: Keith Galliher Law Firm: Galliher Date Of injury: 11/4/16
Print Name: Joyce Sekera Signature Joyce Sekera

Waiving insurance/ Attorney only

I have health insurance; the name of my insurance is: Medicaid, however I choose not to use my health insurance. Therefore, please bill all of my office visits and or charges directly to the attorney listed below:
Attorney name: Keith Galliher Law Firm: Galliher Date Of injury: 11/4/16
Print Name: Joyce Sekera Signature Joyce Sekera

Worker's Compensation:

I have a Work Comp claim;

_____ _____ _____
Company name laim Number Date of Injury

_____ _____
Adjuster Name Adjuster Phone

JS622

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Social Media Site Used: [ ] Facebook [ ] Twitter [ ] Pinterest [ ] Instagram [ ] Other: _____

Referring Source: [ ] _____ [ ] _____ [ ] _____
Physician/health care provider Friend/ Relative Insurance book or website
[ ] _____ [ ] _____ (*Circle if applicable*) Advertisement DISC website Google Yahoo Phonebook
Hospital/ ER name ER PHYSICIAN

Patient Name: SeKeRA (Last Name) Joyce (First Name) P (Middle)

Address: 7840 Nesting Pine Pl (Street) Las Vegas (City) NV (State) 89143 (Zip code) _____ (Country)

Phone: Home (X) _____ Cell (702) 467-5457

Email: JyceseKeRA@Yahoo.com

Employer Phone: (___) _____ Employer Name: _____

Sex: (circle one) Female Male Date of Birth: 3/22/56 Social Security Number: 091-48-8430

Ethnicity: Caucasian Decline ☐ Race: White Decline ☐

Spouse N/A
Last Name, First Name DOB Social Security #

Employer Name: _____ Employer Phone: (___) _____

Emergency contact: MARISSA FREEMAN Relationship: daughter Phone: 702(525-9001)

Primary Insurance Co. Name: _____ Insured Name: _____ Insured DOB: _____

Insured Social Security # ___-___-___ Policy Id# _____ Group# _____

Secondary Insurance Co. Name: _____ Insured Name: _____ Insured DOB: _____

Insured Social Security # ___-___-___ Policy Id# _____ Group# _____

Worker's Compensation: _____ _____
Company Name Address

_____ _____ _____ (___)_____
Claim Number Related Body Part (S) Adjuster Name Adjuster Phone

Attorney Lien: Keith Gallihe R (Attorney name) 702 735 0049 (Law office phone) (___) _____ (Law office fax) 11/4/16 (Date of accident)

Med Pay Co. Name: _____ Contact: _____ Phone: _____

Claim#: _____ Claims Address: _____

If Insurance is not to be billed: _____
Patient signature

Please be advised that if you later decide to bill health insurance it will be billed from that time and date only.

Patient Signature: _____ Date: 10/5/17

By signing this form I hereby consent to and authorize medical treatment, tests, and procedures performed in the office that the physician Deems advisable and necessary based on his/her judgment.

Notice of Privacy Information Practices of Andrew M. Cash MD policy regarding minimum necessary uses and disclosures of protected health information. ☑ I accept or ☐ I decline to receive a copy of privacy practices.

JS623

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Fax: 702-946-5115

X-RAY CONSENT: During the duration of your care, the doctor may feel that x-rays will be needed in order to diagnose your condition. In order to perform x-rays on any patient our office requires the patients consent. I understand that my doctor may need x-rays in order to diagnose my condition. I give permission of all needed diagnostic tests. With full understanding of the above and believing that I am not currently at risk. I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor that I am NOT pregnant. I wish to have an x-ray examination performed today if requested by my doctor will be responsible for any balances due and owing if payment for x-rays is denied.

Signature Patient/Responsible Party Date 10/5/17

NARCOTIC AGREEMENT: Andrew M. Cash MD is dedicated to providing you the best treatment we possibly can. For Dr. Cash to prescribe you pain medication, we require that you read and follow our narcotic contract. Dr. Cash does not prescribe long term narcotic pain medication, if you have ongoing pain that requires chronic pain medication you will be referred to a pain management specialist for all narcotic medication needs. The following medication policy is intended for the safety of our patients and to limit the chance of drug interactions and abuse. I am currently not abusing prescription or non-prescription drugs, and I am not undergoing treatment for addiction or substance abuse. I certify that I have disclosed to my physician any past diagnoses or treatments of psychiatric conditions, drug or alcohol abuse. I agree that while I am being treated with narcotic medication I will abstain from alcohol use. I understand the dangers involved in using alcohol while also taking narcotic medications. I have never been involved in the sale, illegal possession or transport of controlled substance such as narcotic, sleeping pills, pain pills or other illegal substances. I agree to only use one pharmacy for filling of prescriptions, and will supply Dr. Cash with name and number of pharmacy. I agree to allow Dr. Cash to communicate with referring physicians and pharmacists and the Drug Enforcement Agent (DEA) regarding my medications. I understand that Practitioners are required to obtain a PMP Report before Initiating Some Prescriptions for a Controlled Substance. Section 16 of the bill amended the applicable statute, NRS 639.23507(1), such that practitioners are now obligated to obtain a PMP report before "initiating" a controlled substance prescription in most cases. Obligation arises where: 1. prescription is for a controlled substance listed in schedule II, III or IV, and 2. patient is a new patient of the practitioner; or 3. Prescription is for more than 7 days and is part of a new course of treatment for the patient. I agree to take my medications as prescribed; I will not alter my dosage or timing of medications without consulting Dr. Cash. I certify that I am not pregnant, and will stop taking narcotic medications if I become pregnant. I agree to have a urine or blood test done randomly at my physician's request. I understand that lost, stolen or misplaced prescriptions or medications will not be replaced unless you provide proof that a police report has been filed. I understand that narcotic medication may cause drowsiness. If I feel impaired, I will not operate a car or potentially dangerous machinery. I understand that due to the nature of some medications (such as Class II) medications cannot be called in to the pharmacy. If I deviate from the above guidelines, I understand that I will not receive any more medications from Andrew M. Cash, MD and could result in my termination of care.

Signature Patient/Responsible Party Date: 10/5/17

Signature Witness Date: 10/5/17

I **DO NOT** agree to the narcotic agreement, therefore I will **NOT** receive any medications from Andrew M. Cash MD.

Signature Date: _____

PHARMACY: Please list the name, address and phone number of your pharmacy.

Name: Walgreens Pharmacy

Address: 7755 N. Durango

Phone Number (702) 396-4728

JS624

SDMI STEINBERG DIAGNOSTIC

Patient Name: Sakara, Joyce P
DOB: 22-Mar-1956
ID: 790178.0
Study Date: 21-Dec-2016 18:56

Final Report
MR Mri Lumbar Spine Without

Patient: Joyce P Sakara
SDMI #: 790178.0
Pt. DOB: 03/22/1956
Pt. Sex: Female

Date of Service: 12/21/16
SDMI Location: CK

Physician: Jordan Gabber DC
Dr. Fax: (702) 463-9772
Dr. Phone: (702) 463-9508
Dr. Addr.: 7810 W Ann Rd Ste 110 Las Vegas, NV 89149
Cc:
Cc:

MRI LUMBAR SPINE WITHOUT IV CONTRAST

CLINICAL HISTORY:

Lower back pain secondary to fall 2011 415. Bilateral arm and leg pain and numbness as well as weakness.

TECHNIQUE:

Multiplanar imaging is performed without IV contrast. 108 images.

FINDINGS:

The conus medullaris is in normal position with normal signal. Normal lumbar vertebral body height, signal and alignment with discogenic endplate changes at L2, L3, minimally at L4 as well as at L5. Disc desiccation throughout the lumbar spine with normal disc space height.

At T12-L1, no disc bulge or canal stenosis. No neural foraminal narrowing.

At L1-2, mild disc bulge without canal stenosis. AP dimension of the canal at this level 12 mm. No neural foraminal narrowing.

At L2-3, minimal spondylosis and disc bulge with AP dimension of the canal at this level 12 mm without canal stenosis. No neural foraminal narrowing.

At L3-4, mild disc bulge with AP dimension of the canal at this level 11 mm without canal stenosis. No neural foraminal narrowing. Mild facet and ligamentum flavum hypertrophy bilaterally.

At L4-5, left paracentral disc bulge with annular fissuring. AP dimension of the canal at this level 11 mm without canal stenosis. Facet and ligamentum flavum hypertrophy bilaterally. No neural foraminal encroachment.

At L5-S1, central disc bulge with facet hypertrophy bilaterally. AP dimension of the canal at this level 10 mm without canal stenosis. No neural foraminal narrowing noted. There is note made of a synovial cyst measuring 8 mm extending posteriorly of the left facet joint into the paraspinous musculature without neural impingement.

IMPRESSION:

Multilevel lumbar degenerative disc disease with disc bulges extending from L1-2 through L5-S1. Annular fissuring at L4-5. No canal stenosis or neural foraminal narrowing at any level. There is note made of facet and ligamentum flavum hypertrophy at multiple levels.

JS625

Interpreted By: Saul Ruben M.D. 12/22/2016 8:07 AM

Electronically approved By: Saul Ruben, M.D. Date: 12/22/16 08:41

Signed by: Ruben, Saul Signed on: 22-Dec-2016 08:41

SDMI STEINBERG DIAGNOSTIC

Patient Name: Sakura, Joyce P
DOB: 22-Mar-1956
ID: 790179.0
Study Date: 21-Dec-2016 16:40

Final Report
MR Mri Cervical Spine Without

Patient: Joyce P Sakura	Physician: Jordan Webber DC
SDMI #: 790179.0	Dr. Fax: (702) 463-9772
Pt. DOB: 03/22/1956	Dr. Phone: (702) 463-9508
Pt. Sex: Female	Dr. Addr.: 7810 W Ann Rd Ste 110 Las Vegas, NV 89149
Date of Service: 12/21/16	Cc:
SDMI location: CH	Cc:

MRI CERVICAL SPINE WITHOUT CONTRAST

CLINICAL HISTORY:

Neck pain and Bilateral arm numbness, pain, weakness

TECHNIQUE:

T1 sagittal, T2 sagittal and axial T2 images were obtained. 117 images.

COMPARISON:

None

FINDINGS:

There is mild dextrocurvature centered at C5-7. There is straightening of the cervical lordosis. Vertebral bodies are normal in alignment. Vertebral body heights are maintained. Bone marrow signal is normal. Spinal cord is normal in signal. The paravertebral soft tissues appear unremarkable. The intervertebral discs throughout the cervical spine are desiccated without significant loss of height.

C2-3: No disc bulge, spinal canal or neuroforaminal stenosis.

C3-4: No disc bulge, spinal canal or neuroforaminal stenosis. Mild bilateral facet hypertrophy.

C4-5: No disc bulge, spinal canal or neuroforaminal stenosis. Mild left uncovertebral arthropathy. Mild bilateral facet hypertrophy.

C5-6: Mild broad disc protrusion. Spinal canal AP diameter of 12 mm. Bilateral facet hypertrophy. Bilateral uncovertebral arthropathy. Mild left greater than right neuroforaminal stenosis.

C6-7: Mild broad disc protrusion. Spinal canal AP diameter of 10 mm. No significant neuroforaminal stenosis.

C7-T1: No disc bulge, spinal canal or neuroforaminal stenosis.

IMPRESSION:

JS627

Mild multilevel degeneration. Mild neuroforaminal stenosis at C5-C6. No spinal canal stenosis throughout. Mild dextrocurvature. Straightening of the cervical lordosis which may be seen with muscle spasm.

Interpreted By: Sarah Kym MD 12/22/2016 8:20 AM

Electronically approved by: Sarah Kym MD Date: 12/22/16 10:47

Signed by: Kym, Sarah E Signed on: 22-Dec-2016 10:47

JS628

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: **Joyce P Sekera**
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: November 30, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: The patient is s/p diagnostic facet joint / facet nerve injections from which she noted significant but transient improvement. The patient is an appropriate candidate for radiofrequency ablation.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT RADIOFREQUENCY RHIZOTOMY BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, insulated radiofrequency needle(s) were inserted percutaneously and directed to the lateral base of the superior articulating process corresponding to the location of each nerve to be lesioned. Needle position was verified in multiple fluoroscopic views. Each nerve was stimulated at 2 hz (motor) to verify needle proximity to the medial branch to be lesioned. Next, each nerve was stimulated at 2 hz 2 volts rule out major motor stimulation. Prior to lesioning, each nerve was anesthetized. Each nerve was then lesioned. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Fentanyl Midazolam
NEEDLE: 18g RF insulated Venom
LESION: 80 degrees C for 90 seconds for one lesion each side
INJECTATE (each site): Bupivicaine (pf) 0.5% final concentration. 1 ml injected into each site.

Copy to: Andrew Cash MD

Electronically signed by KATHERINE TRAVNICEK Date: 11/30/2017 Time: 14:38:19

JS629

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-675-4600
702-675-4604 fax

PATIENT: Joyce P Sekera
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: May 8, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED DIAGNOSTIC FACET JOINT MEDIAL BRANCH BLOCKS BILATERAL L5-S1 WITH CONSCIOUS SEDATION
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a stylelled spinal needle was inserted percutaneously and directed to the lateral base of the superior articulating process at corresponding to each nerve to be anesthetized. Each site was then injected with contrast to confirm location and to rule out intravascular injection. Each site was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.

SEDATION (medications titrated to effect): Alfentanil Midazolam
CONTRAST: Omnipaque
INJECTATE (each site): Lidocaine (pf) 2% final concentration 0.5 ml injected into each site.
PROCEDURE NEEDLE: 22g Quinke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 5/08/2017 Time: 13:36:07

JS630

PROCEDURE NOTE

VALLEY VIEW SURGERY CENTER
1330 S. Valley View Blvd.
Las Vegas, NV 89102
702-875-4600
702-875-4604 fax

PATIENT: Joyce P Sekera
DOB: 3/22/1956

SURGEON: Katherine D Travnicek MD

Date of Service: March 9, 2017

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

INFORMED CONSENT: Medical history was reviewed with the patient and brief physical examination performed. No contraindications to the procedure were noted. Informed consent was obtained and verified. The procedure was explained in detail. The major risks of the procedure were explained to the patient including but not limited to bleeding, infection, blood clots, spinal headache, increased pain, damage to nerves and structures of the neck/back that can result in temporary or permanent pain, weakness or paralysis, loss of bladder or bowel control, allergic or other reactions to medication requiring resuscitation, air in the lung requiring chest tube, seizure, stroke or death. Injection of corticosteroids can potentially cause suppression of the adrenal gland and damage to bone, tissues or eyes. Transient fluid retention is common. The patient indicates understanding and accepts the risks.

INDICATION: This is a diagnostic and therapeutic injection.

PROCEDURE(S) PERFORMED: FLUOROSCOPICALLY DIRECTED FACET JOINT INJECTION(S) BILATERAL L5-S1
The patient was positioned prone. Standard monitors were connected including pulse oximetry, NIBP and EKG. Supplemental Oxygen was given as needed. The skin was prepped with a sterile surgical prep times three. Sterile drapes were applied. Meticulous sterile technique was maintained. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. Next, under direct fluoroscopic guidance, a stylated procedure needle was inserted percutaneously and directed to the posterior aspect of each facet joint to be injected without paraesthesia. Each site was then injected with contrast to confirm flow into the joint and to rule out intravascular or intrathecal injection. Each joint was then injected. All injected medications were preservative free. Injection was made slowly after negative aspiration for blood and cerebrospinal fluid. The needles were cleared of injectate and removed. The patient tolerated the procedure well. Vital signs remained stable and there were no complications. The patient was taken to the recovery area and monitored until discharge criteria were met. The patient was given discharge instructions including instructions to contact me with any questions or concerns following this procedure. Follow-up instructions were given. The patient was then discharged alert, oriented to his/her driver.
CONTRAST: Omnipaque
INJECTATE (each site): Decamethasone 4 mg (pf) in Marcaine (pf) 0.5% final concentration. 1 ml injected into each site.
PROCEDURE NEEDLE: 22g Quincke

POST-PROCEDURE PAIN: 100% reduction in usual pain.

Electronically signed by KATHERINE TRAVNICEK Date: 3/09/2017 Time: 11:21:44

JS631

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-6262
Fax 702-878-6996

OFFICE VISIT

Date of Service: October 23, 2017

Patient Name: Joyce P Salans
Patient DOB: 3/22/1968

PAIN COMPLAINTS
Neck
Low back

Joyce returns today for follow up. She was trying to avoid the RFA but her back pain is bad enough now she wants to proceed. VAS is a 6 today. She say her pain is in the same location, does not radiate down her legs, and feels achy, sharp, and shooting at times. She came in to discuss the RFA and agrees to proceed.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unable to work due to pain
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Facet ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
03/09/2017
FJ B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief then pain returned.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.5

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 1 tablet daily

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

JS632

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Insomnia

VITAL SIGNS
Height: 66.00 Inches
Weight: 202.00 Pounds
Blood Press: 118/78 mmHg
Pulse: 84 BPM
Respirations: 18 RPM
BMI: 32.6
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mild discomfort
Transition: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

LUMBAR SPINE
Tenderness: Moderate tenderness noted bilateral lower lumbar spine.
Spasm: Mild spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted bilateral L5-S1
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with pain.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

COUNSELING
Radiofrequency Rhizotomy
The patient received extensive counseling regarding radiofrequency rhizotomy (RFR). The procedure to be performed was explained in detail using skeletal and anatomic model. The patient understands that RFR is a neurodestructive procedure intended to cauterize nerves for pain relief. It is expected that the nerves will re-generate in 6-24 months and repeat RFR would be needed if the pain returns. The type of sedation to be used was explained as well. All questions were answered.

Informed Consent: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, discitis, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of airway, pneumothorax, seizure, stroke, paralysis and death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dimpling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

PRESCRIPTIONS
Medication Management: I have reviewed the patient's medications with the patient including the potential risks and side effects.

Start GABAPENTIN 300MG , Qty: 30, Refills: 1, sig: TAKE 1 QHS for NERVE PAIN for RFA pain flare

Start CELEBREX 200MG, Qty: 60, Refills: 1, sig: TAKE 1 BID for PAIN
Prid by 73/TRAVI on 10/23/2017 at 04:21 PM

PLAN
** RADIOFREQUENCY RHIZOTOMY (64635) BILATERAL L5-S1
** Meds above
** RETURN: 3 weeks for re-evaluation with gn / kd

JS633

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 10/23/2017 Time: 16:22:21

Name: SEKERA, JOYCE
DOE: 10-23-2017

RADAR MEDICAL GROUP, LLP

Mailing address: 10624 South Eastern Avenue, Suite A-425, Henderson, NV 89052
Phone (702) 644-0500 Fax (702) 641-4600

Russell J. Shah MD
Neurology /Neurophysiology

NEUROLOGY Follow Up

PATIENT NAME: SEKERA, JOYCE
DOB: 03-22-1956
Gender: F
Date of Injury: 11-04-2016
Date of Evaluation: 10-23-2017

JOYCE SEKERA was seen on 10-23-2017 for a neurologic follow up evaluation.

HISTORY OF INJURY

Date of Injury: 11-04-2016

Medications:

DATE	NAME	DOSAGE	SIG	DISCONTINUE DATE
10-23-2017	Metformin			
07-10-2017	METFORMIN			
07-10-2017	CELEBREX			
05-02-2017	methocarbamol			
05-02-2017	ibuprofen			
04-11-2017	ZPAK		AS DIRECTED	
02-07-2017	ROBAXIN	UNKNOWN	PRN	
02-07-2017	METHOCARBOMOL	UNKNOWN	TWICE DAILY PRN	
12-20-2016	IBUPROFEN	600MG	1 TAB PRN HA	

REVIEW OF SYSTEMS

JS635

Name: SEKERA, JOYCE
DOE: 10-23-2017

She has left neck pain, left upper back pain, left behind the shoulder pain and tingling mainly with limited neck ROM

She is still with forgetfulness and has problems with recall/remembering. She has improved partially but is still not normal

She is on metformin for diabetes

She is not taking the flexeril medications

She notes improvement with the Aricept and no side effects

EXAMINATION

Vital Signs:

TEMP	PULSE	RESP	HT	WT	BMI	BP SYST	BP DIAST	COMMENT	SPO2
98.6	51	16	66	202	33	138	81		98

General: The patient is awake, alert appropriate and non-toxic appearing
The patient appears to be in no distress.
The patient has a clear sensorium
The patient is a fair historian, Mood appears okay, no staring off,
oriented, insightful, follows commands, okay simple naming, spelling and calculations

Obesity

Cranial Nerves: EOMI
Hearing was intact.
The smile is symmetric.

Motor :

Normal power
Reflexes 2 to 2+

Coordination: Unremarkable

Gait: Nonwide based gait which is symmetric.

Romberg was performed and demonstrated with no sway.

JS636

IMPRESSION from 11/4/2016 Trauma

1. Post traumatic brain syndrome

- restart aricept after discussion of memory and recall still a issue at this time (MRI and EEG, as well as labs reviewed today)
- may need further imaging
- re-evaluate in 4 months
- addiction, off label, drug induced hepatitis, worsening of diabetes and interaction, withdrawl, alternatives, not taking medication and regular condition, exercises and mind stimulations exercises (ie AARP discussed)

2. Cervical strain/headaches

- spine restrictions

3. Lumbar strain with leg pain/ache

- spine restrictions
- weight loss

4. Carpal tunnel syndrome

- wrist splints
- education
- neurodiagnostic studies in 6 months if the symptoms persist
- hand surgeon if symptoms persist
- compliance

Sincerely,

Russell J. Shah, MD

cc: Dr. Jordan Webber

cc: Dr. Walter Kidwell

cc: Dr. Andrew Cash

Constitutional Normal appetite, normal steady weight, no malaise, no generalized weakness, no diaphoresis, no unexplained weight loss

ENMT Negative unless documented in the HPI and/or Present complaints. No sore throat, no painful swallowing, no change of speech, (-) slurred speech, no tongue numbness, no perioral numbness

Cardiac: Negative unless documented in the HPI and/or Present complaints. No palpitations, no chest pain, no shortness of breath during activities is present. No syncope

Respiratory: Negative unless documented in the HPI and/or Present complaints. No asthma, no bronchitis, no fever, no chills, no coughing and no shortness of breath is present.

GI: Negative unless documented in the HPI and/or Present complaints. (-) nausea, no vomiting, no diarrhea and no constipation is present. No blood in the stool

GU: Negative unless documented in the HPI and/or Present complaints. No bowel urgency, (-) bladder urgency, no bowel incontinence, no bladder incontinence, no painful urination, and no blood in the urine

Visual: Negative unless documented in the HPI and/or Present complaints. (-) double vision, (-) blurred vision and (-) eye pain is present.

Neurologic: Negative unless documented in the HPI and/or Present complaints. (+) headache, (+) neck pain, (+) mid back pain, (+) low back pain, (+) weakness in the arms, (+) weakness in the hands, (-) weakness in the legs, (-) weakness on walking, (-) numbness or tingling in the arms, (-) numbness or tingling in the legs.

Psychiatric: Negative unless documented in the HPI and/or Present complaints. (-) depression, (-) anxiety, (+) restlessness, no sleep onset difficulties, no active or recent suicidal ideation, thought, attempt or plan.

RECORD REVIEW

chart

PRESENT COMPLAINT

She has low back pain and is not taking Celebrex and is to see Pain management at Dr. Kidwell now. She has seen Dr. Andrew Cash for the low back

She is no longer working as a ticket sales type positioin

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 100
Las Vegas, NV 89130
Tel 702-876-8262
Fax 702-876-9099

CONSULT

Date: January 9, 2017

Patient: Joyce P Sakara
DOB: 9/23/1956

Referred By: Jordan Webber , DC

PAIN COMPLAINTS
Neck
Low back
Bilateral knee pain

60 year old female here today with the above complaints that started after a slip and fall backwards at work. She was walking and slipped on a liquid that was on the floor. She says she can't remember the whole event as she hit her head and was dazed. She went to the hospital, was treated and released. She has been in chiropractic since and feels it helps. She has neck, low back and bilateral knee pain. She denies history of prior injuries or chronic pain of these areas also. She has cervical, brain and lumbar MRIs, reports reviewed but no images available for review.

She reports her neck pain is bilateral and radiates into both shoulders. She denies pain radiating down her arms. She has numbness and tingling in both hands. She denies weakness, gait changes, and bladder and bowel dysfunction.
Activities that aggravate the pain: Constant pain, looking up and side to side
Activities that relieve the pain: Exercise and heat, cold, chiro, Ibuprofen (she takes 1 every other day), traction
Description of the pain: Tingling, numbness, and constant ache
Least pain throughout day (0-10): 4/10
Most pain throughout day (0-10): 8-9/10
Non-helpful treatments: Roller table

Her low back pain is bilateral and does not radiate down her legs. She denies numbness, tingling and weakness in her legs. She also denies saddle anesthesia. Her knee pain is separate and there is some swelling in her knees that comes and goes. She denies redness, increased warmth and fevers.
Activities that aggravate the pain: Constant, bend, lift, twist, leaning back
Activities that relieve the pain: Exercise and heat and ice
Description of the pain: Constant ache
Least pain throughout day (0-10): 4/10
Most pain throughout day (0-10): 8/10

INJURY HISTORY
Date of Injury: 11/04/2016
Accident Description: Slipped on some liquid at work.
Urgent Care: No
Hospital: Yes.
Hospital Name / Location: Centennial Hospital
Length of stay: Few hours
Ambulance Transport: No
Hit Head: Unknown
Loss of consciousness: Yes, Brief.
Pain started: Immediately after the impact.
Initial Injuries to patient: Left arm pain
What injuries have improved?: Left elbow pain
What injuries have not improved?: Neck and low back pain
Treating physicians regarding this injury: Jordan Webber, DC
Chiropractic Therapy: Yes. Currently in treatment. Weeks of therapy: 8
Physical Therapy: None
Osteopathic Manipulation Therapy: None
Massage Therapy: Yes
Acupuncture: None
MRI: Yes Brain , cervical, and lumbar
Prior treatments to spine: None
Spine Injections: None
Radiofrequency Rhizotomy: None
Discectomy: None
Spinal Cord Stimulator: None
Neck or back surgery: None
Prior neck injuries: None
Prior neck pain: None
Prior back injuries: None
Prior back pain: Yes. Lumbar pain 3 years ago - resolved after 1 day
Prior MVA's: None
Prior work comp claims: None
Sitting Time: < 15 minutes
Standing time: < 15 minutes
Walking time: < 15 minutes
Lifting: Can only lift 15 lbs due to pain.

JS640

DIAGNOSIS
M54.2 NECK PAIN
M50.22 MID CERVICAL DISCOPATHY
M47.812 CERVICAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M54.5 LOW BACK PAIN
M51.26 LUMBAR DISCOPATHY
M51.27 LUMBOSACRAL DISCOPATHY
M47.816 LUMBAR FACET JOINT ARTHROPATHY / SPONDYLOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M62.838 MUSCLE SPASM
W19 H/O SLIP AND FALL

DISCUSSION
Neck pain - I suspect facet and disc mediated pain. MRI report indicates disc protrusions at C56 and C67 levels and bilateral facet hypertrophy.

Low back pain - I suspect facet and disc mediated pain. MRI lumbar spine report indicates a L45 annular fissure and bilateral facet hypertrophy at various levels.

She has not taken any medications besides as needed ibuprofen. I'll have her change to Naproxyn and robaxin for 2 weeks straight then stop and see her back in 3 weeks time to re-evaluate. She denies history of prior injuries to her neck and low back. Thus, it's more likely than not that her pain is causally related to the fall on 11-4-2016.

PRESCRIPTIONS
Medication Management: I have reviewed the patient's medications with the patient including the potential risks and side effects.

Start NAPROXEN 500MG, Qty: 30, Refills: 0, sig: TAKE 1 BID for PAIN 2 weeks

Start ROBAXIN 500MG, Qty: 30, Refills: 0, sig: TAKE 1 BID for SPASM
Prtd by SS/CLARY on 01/09/2017 at 08:12AM

PLAN
** CONTINUE CURRENT CHIROPRACTIC THERAPY
** Meds as above
** RETURN: 3 weeks for re-evaluation with ldt

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 1/09/2017 Time: 13:39:35

Driving: Not limited by pain
Sleep: Is disturbed by pain.
ADL's: Unlimited - she has trouble bending to put on pants/shoes
Work: Pt is unable to work due to pain
Usual Occupation: Customer service

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular tearing. And ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

MEDICAL HISTORY
No medical problems reported by patient.

ALLERGIES
No known drug allergies

MEDICATIONS
Ibuprofen 800mg prn

NV PMP REVIEWED 1/4/13-1/4/17

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service
Habits: The patient smokes less than 1/2 pack per day. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Blurred vision decreased vision
ENT: Headache
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: Negative
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Anxiety depressed mood Insomnia

VITAL SIGNS
Height: 66.00 Inches
Weight: 208.00 Pounds
Blood Press: 120/78 mmHg
Pulse: 72 BPM
BMI: 33.6
Pain: 09

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Translation: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

CERVICAL SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Head position: Head is in neutral position. No abnormal posturing or torticollis.

JS642

Tenderness: None noted.
Trigger Points: None noted.
Spasm: No spasm noted.
Facet Tenderness: No facet joint tenderness noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with pain in flexion mostly.
Negative Spurling's on left
Negative Spurling's on right

Motor/Strength Testing:
Deltoid (C5): L 5/5, R 5/5
Biceps (C5 + C6): L 5/5, R 5/5
Triceps (C7): L 5/5, R 5/5
Wrist extension (C6): L 5/5, R 5/5
Wrist flexion (C7): L 5/5, R 5/5
Grip (C8): L 5/5, R 5/5
Interossei (T1): L 5/5, R 5/5

Sensory:
C5: Normal bilaterally
C6: Normal bilaterally
C7: Normal bilaterally
C8: Normal bilaterally
T1: Normal bilaterally

Reflexes:
Biceps (C5): Left 2+, right 2+
Brachioradialis (C6): Left 2+, right 2+
Triceps (C7): Left 2+, right 2+
Negative hoffmans bilaterally

THORACIC SPINE
Appearance: No masses, lesions or abnormalities. Spine appears straight.
Palpation: No Tenderness, trigger points, or spasm.
Range of Motion: Full range of motion.
Sensory: Intact in all dermatomes.

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: Spine is straight and in normal alignment.
Tenderness: None noted.
Trigger Points: None noted.
Spasm: No spasm noted.
Facet Tenderness: No facet joint tenderness noted.
Spinous Tenderness: Spinous processes are non-tender.
ROM: Full ROM with pain in flexion
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

Motor/Strength Testing:
Hip flexion (L2-L3): L 5/5, R 5/5
Hip abduction (L4-S1): L 5/5, R 5/5
Knee extension (L3-L4): L 5/5, R 5/5
Knee flexion (L5-S1): L 5/5, R 5/5
Ankle inversion (L4): L 5/5, R 5/5
Ankle eversion (S1): L 5/5, R 5/5
Ankle dorsiflexion (L4, L5): L 5/5, R 5/5
Ankle plantarflexion (S1): L 5/5, R 5/5
EHL (L5): L 5/5, R 5/5

Sensory:
L1: Normal bilaterally
L2: Normal bilaterally
L3: Normal bilaterally
L4: Normal bilaterally
L5: Normal bilaterally
S1: Normal bilaterally

Reflexes:
Knee (L4): Left 2+, right 2+
Ankle (S1): Left 2+, right 2+
No Clonus bilaterally

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-8096

OFFICE VISIT

Date of Service: January 30, 2017

Patient Name: Joyce F Sakara
Patient DOB: 3/22/1966

PAIN COMPLAINTS
Neck Pain
Low Back Pain
BL Knee Pain
BL Shoulder Pain

Joyce returns today for follow up. She is feeling better overall with Naproxyn PRN and chiro. She was afraid of Robaxin as she got the generic form which starts with "metho-" and didn't want any episode so didn't take this. We discussed meds at length again today.
Neck pain is constant and feels stiffness now. VAS 4-7 and mostly moderate pain. Made better by chiro and naproxyn.
Low back pain is constant and achy. She thinks this is mostly moderate pain.
She no longer has severe pain. She is not working and feels she can't do her job. I encouraged finding desk work or another job.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unable to work due to pain
Therapy: Pt is currently receiving chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

MEDICAL HISTORY
No medical problems reported by patient.

ALLERGIES
No known drug allergies

MEDICATIONS
Naproxen 500mg PRN

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with: family
Occupation: Customer service
Habits: The patient smokes less than 1/2 pack per day. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Blurred vision decreased vision
ENT: Headache
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative

JS644

Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Anxiety depressed mood insomnia

VITAL SIGNS
Height: 66.00 Inches
Blood Press: 114/80 mmHg
Pulse: 66 BPM
Respirations: 16 RPM
Pain: 08

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Translation: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

CERVICAL SPINE
Appearance: No masses, lesions or abnormalities. Normal head position.
Palpation: No Tenderness, trigger points, or spasm.
Range of Motion: Full range of motion in flexion, extension and rotation.

LUMBAR SPINE
Appearance: No masses, lesions or abnormalities. Normal head position.
Palpation: No Tenderness, trigger points, or spasm.
Range of Motion: Full range of motion in flexion, extension and rotation.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M54.2 NECK PAIN
M54.5 LOW BACK PAIN
M62.838 MUSCLE SPASM

PRESCRIPTIONS
Medication Management: I have reviewed the patient's medications with the patient including the potential risks and side effects. The patient has been counseled not to sell, share, are otherwise distribute his or her medications with other people. The patient understands that all medications can have adverse effects such as impairment and that dangerous activities such as driving are prohibited while impaired. The patient is advised not to drink alcohol while taking controlled substances. The patient is advised not to drive after taking controlled substances. The patient understands that the risks of opiate-type medications and other controlled substances potentially include addiction, tolerance, withdrawal, and accidental over dosage and that death can result from accidental over dosage. It was emphasized to the patient take the medications exactly as prescribed. The appropriate use and issues regarding misuse were discussed in detail. These discussions included appropriate federal and state law. Compliance to the treatment plan was emphasized. The patient reports no intolerable side effects. The patient is compliant. No aberrant behavior is noted. No impairment is noted. The patient is appropriate to receive medication(s).

Start ROBAXIN 500MG, Qty: 30, Refills: 0, sig: TAKE 1 BID for SPASM
Prid by 73/TRAV1 on 01/30/2017 at 08:59 AM

Start GABAPENTIN CAPSULE 300MG, Qty: 30, Refills: 0, sig: TAKE 1 QHS for PAIN
Prid by 73/TRAV1 on 01/30/2017 at 08:59 AM

PLAN
** CONTINUE CURRENT CHIROPRACTIC THERAPY
** Continue naproxyn prn
** Meds as above
** RETURN: 3 weeks for re-evaluation with MD

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 1/30/2017 Time: 8:51:45

JS645

PAIN INSTITUTE OF NEVADA
7496 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-6252
Fax 702-878-6098

OFFICE VISIT

Date of Service: February 20, 2017

Patient Name: Joyce P Selams
Patient DOB: 3/22/1968

PAIN COMPLAINTS
BL Shoulder Pain
Low Back Pain

Joyce returns today for follow up. She has no neck pain but does have bilateral top of shoulder pains. VAS is 6 today. Constant ache and made worse with arm reaching and shoulder movements. Pain improved with chiro, heat, and medications. We discussed trigger point injections and she would like to proceed. She also didn't start gabapentin after she read all of the adverse effects she could have. I will get her labs done in Jan 2017 and review with her next time.

Low back pain: VAS is 6 today. VAS ranges 2-7. She reports a constant ache, pain worse with lumbar extension. She denies leg symptoms. Feels better with heat, massage, chiro, naprosyn and robaxin. We discussed lower lumbar facet joint injections and she would like to proceed.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unable to work due to pain
Therapy: Pt is currently receiving chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally.
L4-5: Left paracentral disc bulge with annular tearing. Assessment and ligamentum flavum hypertrophy bilaterally.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

MEDICAL HISTORY
No medical problems reported by patient

ALLERGIES
No known drug allergies

MEDICATIONS
Naproxen 500mg bid
Robaxin 500mg bid

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes less than 1/2 pack per day. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Blurred vision decreased vision
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative

JS646

** CONTINUE CURRENT CHIROPRACTIC THERAPY
** DIAGNOSTIC / THERAPEUTIC FACET JOINT INJECTION (64493) BILATERAL L5-S1
** RETURN: 1 week trigger point injections with gn
** RECORDS FROM: Lab work done in Jan, to re-assess gabapentin dose for her
** RETURN: 3-4 weeks for re-evaluation with kdl

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 2/20/2017 Time: 8:40:01

PAIN INSTITUTE OF NEVADA
7436 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8252
Fax 702-878-8096

OFFICE VISIT

Date of Service: March 15, 2017

Patient Name: Joyce P Sakara
Patient DOB: 3/22/1956

PAIN COMPLAINTS
Neck pain
Low back pain

Joyce returns today after facet joint injections.
The patient is s/p facet joint injection bilateral L5-S1
Immediate post procedure pain: 100% relief of usual pain for 6 hours
Sustained improvement: None
Symptoms are getting worse. VAS is 8 today.
Function is declining. She takes no medications right now.
Repeat injection is recommended - bilateral medial branch blocks at L5S1 and then RFA if she has second positive block

Her neck pain is bad today also. She has bilateral shoulder muscle pains, and trigger points weren't that successful she feels and would not like to repeat.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unable to work due to pain
Therapy: Pt is currently receiving chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular fissuring. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
03/09/2017
FJI B L5S1
Post injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

MEDICAL HISTORY
No medical problems reported by patient

ALLERGIES
No known drug allergies

MEDICATIONS
No medication

NV PMP REVIEWED 1/4/13-1/4/17

SURGICAL HISTORY

JS648

PRESCRIPTIONS
Medication Management: I have reviewed the patient's medications with the patient including the potential risks and side effects.

Start CELEBREX 200MG, Qty: 42, Refills: 0, sig: TAKE 1 BID for PAIN
Prtd by KSMEGAY on 3/15/2017 at 01:50PM

PLAN
** DIAGNOSTIC FACET MEDIAL BRANCH BLOCKS (64493) BILATERAL L5-S1
** Celebrex start today
** RETURN: 1 week after injection with pn / kdl

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 3/15/2017 Time: 13:56:01

JS649

No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service /Unemployed
Habits: The patient smokes less than 1/2 pack per day. The patient does not drink . The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Insomnia

VITAL SIGNS
Height: 66.00 inches
Blood Press: 128/73 mmHg
Pulse: 74 BPM
Pain: 08

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Significant pain
Transition: Slight limited
Ambulation: Patient can ambulate without assistance.
Gait: Gait is antalgic

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness , lesions, swelling or deformities.
Alignment: Spine is straight and in normal alignment.
Tenderness: Severe tenderness noted bilateral left > right L5-S1
Trigger Points: None noted.
Spasm: Moderate spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted left > right L5-S1
Spinous Tenderness: Spinous processes are non-tender.
ROM: Range of motion is decreased due to pain.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M54.2 NECK PAIN
M79.1 MYOFASCIAL PAIN
M62.838 MUSCLE SPASM
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY /SPONDYLOSIS

COUNSELING
Spine Injections
Informed Consent for Spine Procedures: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, discitis, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of airway, pneumothorax, seizure, stroke, paralysis and death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dimpling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Anxiety depressed mood insomnia

VITAL SIGNS
Height: 66.00 Inches
Blood Press: 166/80 mmHg
Respirations: 16 RPM
Pain: 08

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Transition: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

CERVICAL SPINE
Appearance: No masses, lesions or abnormalities. Normal head position.
Palpation: No Tenderness, trigger points, or spasm.
Range of Motion: Full range of motion in flexion, extension and rotation.
Motor: All 5/5 in the upper extremities.
Sensory: Intact in the upper extremities.
Reflexes: 2+ and equal in the upper extremities.

LUMBAR SPINE
Appearance: Grossly normal. No scars, redness, lesions, swelling or deformities.
Alignment: Spine is straight and in normal alignment.
Tenderness: Mild tenderness noted bilateral lower lumbar spine.
Trigger Points: None noted.
Spasm: Mild spasm is noted in the paravertebral musculature.
Facet Tenderness: Facet joint tenderness is noted bilateral L5-S1
Spinous Tenderness: Spinous processes are non-tender.
ROM: Range of motion is decreased due to pain.
Straight Leg Raising: Negative at 90 deg bilaterally. Does not produce radicular pain.

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No signs of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M62.838 MUSCLE SPASM
M79.1 MYOFASCIAL PAIN
M54.5 LOW BACK PAIN
M47.816 LUMBAR FACET JOINT ARTHROPATHY / SPONDYLOSIS
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

COUNSELING
Spine Injections
Informed Consent for Spine Procedures: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, discitis, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of sensory, pneumothorax, seizure, stroke, paralysis and death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dimpling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

Trigger Point Injections - done today
The patient was counseled regarding trigger point injections. The injections were described to the patient in detail. The risks and benefits were also reviewed.

PROCEDURE NOTE
TRIGGER POINT INJECTIONS- Informed consent was obtained, risks reviewed. The sites to be injected were identified and prepped with alcohol. Injections were performed without difficulty or complication.
Muscle(s) Injected: Bilateral trapezius muscles levator scapula
Local: Marcaine 0.26% mixed in Lidocaine 2% and a total of 7 ml used out of 10 ml prepared.
Post Injection: 80% relief of usual bilateral shoulder pain

PLAN

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-8262
Fax 702-878-8696

OFFICE VISIT

Date of Service: June 26, 2017

Patient Name: Joyce P Salera
Patient DOB: 3/22/1958

PAIN COMPLAINTS
Neck
Mid back

Joyce returns to clinic today.
The patient is s/p medial branch blocks bilateral L5-S1
Immediate post procedure pain: 100% relief of usual pain
Sustained improvemment: None
Symptoms are returning. VAS is a 6/10 her low back today.
Recommendations: RFA bilateral L5S1 facet joint
She wants to think about it.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVAs: No.
Work Status: Unable to work due to pain
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular tearing. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
05/09/2017
RFB L5S1
Post Injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/09/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief. 24 days out No Change.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.6

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 1 tablet 3x a week
Celebrex 200mg PRN 1 tablet a week

NV PMP REVIEWED 6/19/16-6/119/17

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY

Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed
Habits: The patient smokes less than 1/2 pack per day. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Insomnia

VITAL SIGNS
Height: 66.00 Inches
Blood Press: 126/82 mmHg
Pulse: 88 BPM
Respirations: 18 RPM
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: Mod discomfort
Translation: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x2. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal / Homicidal: None.

DIAGNOSES
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS
M62.838 MUSCLE SPASM

COUNSELING
Radiofrequency Rhizotomy
The patient received extensive counseling regarding radiofrequency rhizotomy (RFR). The procedure to be performed was explained in detail using skeletal and anatomic model. The patient understands that RFR is a neurodestructive procedure intended to cauterize nerves for pain relief. It is expected that the nerves will re-generate in 6-24 months and repeat RFR would be needed if the pain returns. The type of sedation to be used was explained as well. All questions were answered.

Informed Consent: The procedure(s) was reviewed with the patient in detail using a skeletal model. All questions were answered. The risk were reviewed and include but are not limited to increase in pain, bleeding, infection, diarrhea, damage to nerves, spinal cord, structures of the neck and back, spinal headache, reaction to medication, loss of airway, pneumothorax, seizure, stroke, paralysis and death. No guarantees were made regarding outcome. The risks of injection of corticosteroids include but are not limited to thinning of bones, fractures, avascular necrosis of the hips, cataracts, weakening of structures such as ligaments, fat necrosis, dangling of skin, adrenal suppression. Common side effects include water retention, flushing, insomnia, increased pulse and blood pressure. Diabetics will have increased blood sugars for about a week after injection. The patient has the option for sedation for the procedure. I advised the patient that conscious sedation may be utilized to provide a "twilight" effect. The patient will be arousable and able to respond throughout the procedure. This will not be a deep sedation. The patient may or may not have recall of the procedure. The risk of sedation includes loss of airway, aspiration, reaction to medication and damage to nerves.

PRESCRIPTIONS
None

PLAN
** RETURN: 2 weeks for re-evaluation with MD

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 8/28/2017 Time: 14:38:36

JS653

PAIN INSTITUTE OF NEVADA
7435 W. Azure Drive , Ste 160
Las Vegas, NV 89130
Tel 702-878-6252
Fax 702-878-6986

OFFICE VISIT

Date of Service: July 10, 2017

Patient Name: Joyce F Salera
Patient DOB: 3/22/1966

PAIN COMPLAINTS
Neck Pain
Low back pain

Joyce returns today for follow up. She declines the RFA procedure for her low back pain. VAS ranges 0-6 and comes and goes. She doesn't feel her pain is severe enough to get the RFA and she wants a permanent solution. She takes celebrex as needed. She will return here when she is ready to do the RFA should her pain worsen.

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Unemployed
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumber spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular tearing. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
03/08/2017
FJB L5S1
Post Injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/08/2017
MBB BLS1
Post Injection: Complete Resolution of usual pain.
Sustained: 2 days at 100% relief. 24 days out No Change.

MEDICAL HISTORY
Diabetes type 2, HbA1C 6.6

ALLERGIES
No known drug allergies

MEDICATIONS
Metformin 1 tablet 3x a week
Celebrex 200mg 1-2x a month

NV PMP REVIEWED 6/16/16-6/116/17

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family

JS654

Occupation: Customer service / Unemployed
Habits: The patient smokes rarely. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Insomnia

VITAL SIGNS
Height: 66.00 Inches
Blood Press: 128/72 mmHg
Pulse: 62 BPM
Respirations: 18 RPM
Pain: 05

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Transition: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

PRESCRIPTIONS
None

PLAN
** RETURN: As needed

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 7/10/2017 Time: 8:13:00

PAIN INSTITUTE OF NEVADA
7495 W. Azure Drive, Ste 190
Las Vegas, NV 89130
Tel 702-878-6252
Fax 702-878-9096

OFFICE VISIT

Date of Service: May 11, 2017

Patient Name: Joyce P Galeana
Patient DOB: 3/22/1968

PAIN COMPLAINTS
Low Back Pain

Joyce returns for follow up today.
The patient is s/p medial branch blocks bilateral L5-S1
Immediate post procedure pain: 100% relief of usual pain
Sustained improvement: 60% reduction in usual pain. Pain reported 3/10
Symptoms are improving. She has a pinching feeling in her low back that is mild and not limiting her function.
Recommendations: When her pain returns, I recommend an RFA at bilateral L5-S1 joints

INTERIM HISTORY
Hospitalizations or ER visits: None
Changes in health: None
Problems with medications: None
Obtaining pain meds from other physicians: Patient denies.
New injuries or MVA's: No
Work Status: Pt is working full duty.
Therapy: Pt is not currently receiving physical or chiropractic therapy.

IMAGING/TESTING
MRI brain without contrast: Report dated 12/16/2016
Brain normal for age.

MRI cervical spine without contrast: Report dated 12/21/2016
Mild dextrocurvature with straightening of cervical lordosis.
C3-4: Mild bilateral facet hypertrophy.
C4-5: Mild bilateral facet hypertrophy. Mild left uncovertebral arthropathy.
C5-6: Mild disc protrusion with mild bilateral facet hypertrophy. Bilateral uncovertebral arthropathy with mild left greater than right neural foraminal stenosis.
C6-7: Mild broad disc protrusion AP diameter spinal canal 10 mm.

MRI lumbar spine without contrast: Report dated 12/21/2016
L1-2: Mild disc bulge.
L2-3: Minimal spondylosis and disc bulge.
L3-4: Mild disc bulge with mild facet and ligamentum flavum hypertrophy bilaterally. AP dimension of the spinal canal 11 mm.
L4-5: Left paracentral disc bulge with annular tearing. Assessment and ligamentum flavum hypertrophy bilaterally. AP dimension spinal canal 11 mm.
L5-S1: Central disc bulge with facet hypertrophy bilaterally. AP dimension spinal canal 10 mm.

PROCEDURES
03/09/2017
FJR B L5S1
Post Injection: Complete resolution of usual pain
Sustained: No relief of usual pain.

05/09/2017
MBB B L5S1
Post Injection: Complete Resolution of usual pain.
Sustained: 3 days at 100% relief and then now at 60% relief

MEDICAL HISTORY
No medical problems reported by patient

ALLERGIES
No known drug allergies

MEDICATIONS
None

SURGICAL HISTORY
No prior surgeries reported.

FAMILY HISTORY
Lung Cancer

SOCIAL HISTORY
Family Status: Single / not married , has children , lives with family
Occupation: Customer service / Unemployed

JS656

Habits: The patient smokes less than 1/2 pack per day. The patient does not drink. The patient denies recreational drug use.

SYSTEMS REVIEW
Constitutional Symptoms: Fatigue
Visual: Negative
ENT: Negative
Cardiovascular: Negative
Respiratory: Negative
Gastrointestinal: Negative
Genitourinary: Negative
Endocrine: Negative
Musculoskeletal: See HPI
Neurological: Negative
Hematologic: Negative
Integumentary: Negative
Psychological: Insomnia

VITAL SIGNS
Height: 66.00 Inches
Blood Press: 110/68 mmHg
Respirations: 16 RPM
Pain: 03

PHYSICAL EXAMINATION
GENERAL APPEARANCE
Appearance: No discomfort
Transition: Normal
Ambulation: Patient can ambulate without assistance.
Gait: Gait is normal

PSYCHOLOGICAL EXAMINATION
Orientation: The patient is alert and oriented x3. No sign of impairment.
Mood / Affect: Mood is normal. Full affect.
Thought Process: Intact.
Memory: Intact.
Concentration: Intact.
Suicidal Ideation: None.

DIAGNOSIS
M54.5 LOW BACK PAIN
M47.817 LUMBOSACRAL FACET JOINT ARTHROPATHY / SPONDYLOSIS

PRESCRIPTIONS
None

PLAN
** RETURN: 3 weeks for re-evaluation with MRI

Katherine D Travnicek MD

Electronically signed by KATHERINE TRAVNICEK Date: 5/11/2017 Time: 8:35:58

JS657

PAYER INVOICE

Desert Institute of Spine Care
9339 W SUNSET RD
STE 100
LAS VEGAS, NV 89148-4849
702-630-3472
TAX ID #: 208772860

TOTAL AMOUNT DUE: $1,750.00
INVOICE DATE: 12/18/17
DUE DATE: 01/17/18

THE GALLIHER LAW FIRM
1850 E. SAHARA AVE #107
LAS VEGAS, NV 89104

MAKE CHECKS PAYABLE TO :
Desert Institute of Spine Care

DATE	DESCRIPTION	CHARGES	PMT / ADJ / WITHHELD	BALANCE
	Sekera, Joyce Acc. No: 10429 SSN: XXX-XX-8430			
10/05/17	Claim:1962, Provider: Andrew M. Cash, MD			
10/05/17	72050 X-RAY EXAM OF NECK SPINE	$500.00		
10/05/17	72110 X-RAY EXAM OF LOWER SPINE	$400.00		
10/05/17	99244 Office Consultation Level 4	$850.00		
	Claim Balance:			$1,750.00

TOTAL CHARGES : $1,750.00
TOTAL PMT / ADJ / WITHHELD : $0.00
TOTAL AMOUNT DUE : $1,750.00

Desert Institute of Spine Care

This invoice is for outstanding charges. Please return a copy of the invoice with the remittance. Thank you.

JS658

William D. Smith, MD
Jason E. Corban, MD, FACS
Stuart S. Kaplan, MD, FACS
Gregory L. Douds, MD

Western Regional Center for Brain & Spine Surgery

3061 S Maryland Pkwy Suite 200
Las Vegas, NV 89109-0227
Phone: (702) 737-1948
Fax: (702) 737-7195

Patient: Joyce Sokera **Patient #:** 379090 **DOB:** 03/22/1956 (61 years)

Date of Encounter: 02/22/2018

History of Present Illness

The patient is a 61 year old female who presents to the practice today for a transition into care. The patient is transitioning into care and a summary of care was reviewed. Note for "transition into care": I had the opportunity and pleasure of seeing this 61-year-old woman in my office today. This woman works at The Venetian here in Vegas. She is a salesperson who sells show tickets at a booth there. The patient had been there for some time. She was in her usual state of good health when she went to lunch. She slipped on a wet floor while there. She apparently had a loss of consciousness. She was seen by The Venetian medical staff. She was told that she should go to the hospital. She decided to drive herself there. She was seen at Centennial Hospital and released.

Since this accident, she has had severe low back pain. She does have some moderate cervical spine discomfort as well. She feels that 90% of her discomfort is coming from her lower back. She also states that prior to this accident, to her recollection, she has not been seen by a medical professional regarding any spine issues. Over the past year, she has been seen by chiropractic care, Dr. Weber. She has had some mild transient improvement. However, pain has continued to be quite severe. She has been seen by Pain Management. She had several epidural steroid injections without any significant relief.

On 11/30/17 approximately one year after the injury, she did have a facet rhizotomy. She had a five-day relief of her pain, but her pain has now returned. She does not wish to take any type of pain medications. She takes an occasional Tylenol. She does have some improvement in her back pain with changes in position, a heating pad, and recumbency. Bending, lifting, and twisting worsens her pain. Prolonged sitting and not changing her position also worsens her pain. She is here today for a consultation.

Allergies

No Known Allergies 02/26/2018
No Known Drug Allergies 02/26/2018

Past Medical History

No Known Problems (02/26/2018)

Family History

Mother: In good health
Father: Deceased
Brother 1: In good health
Sister 1: In good health

Social History

Occupation/Work Status: Retirement (Health Related)
Marital Status: Single
Children: 1
Living situation: Lives with his mother
Tobacco use: Current some day smoker; Smokes 1-2 cigarettes a week
Alcohol Use: No alcohol use
Illicit drug use: Never
HIV risk factors: None
Highest recreation level prior to spine condition: No Response

Medication History

No Current Medications.

Past Surgical

None (02/26/2018)

Diagnostic Studies

Chiropractor
Exercise Therapy
MRI Brain, Brain Stem
MRI Cervical Spine
MRI Lumbar Spine
Lumbar Spine X-ray

Review of Systems

General Not Present- Excessive Fatigue, Fever, Night Sweats, Weight Gain and Weight Loss.
HEENT Not Present- Balance Disturbance, Cataracts, Ear Infection, Ear Pain, Eye Infection, Eye Injury, Glaucoma, Hearing Loss, Inability to Smell, Nasal Congestion, Nasal Drainage, Nose Bleed, Ringing in the Ears, Sinus Headaches, Sinus Problems, Spinning Sensation, Vertigo, Wears glasses/contact lenses and Wears hearing aids.
Respiratory Not Present- Asthma, Bloody sputum, Chronic Cough and Shortness of Breath.
Breast Not Present- Breast Pain, Breast Swelling, Breast Tenderness and Nipple Discharge.
Cardiovascular Present- **Leg Pain and/or Swelling**. Not Present- Heart Murmur, High Blood Pressure, High Cholesterol, Irregular Pulse and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain, Change in Bowel Habits, Indigestion, Jaundice, Nausea, Vomiting and Vomiting Blood.
Female Genitourinary Not Present- Blood in Urine, Incontinence, Painful Urination, Urinary Frequency and Urinary Urgency.
Musculoskeletal Present- **Arm Weakness**, **Arm Pain**, **Back Pain**, **Joint Swelling**, **Leg Pain** and **Neck Pain**. Not Present- Decreased Range of Motion, Joint Pain and Leg Weakness.
Neurological Not Present- Blacking Out, Blurred Vision, Difficulty with Speech, Disorientation, Double Vision, Face Weakness, Fainting Spells, Headaches, Inability to concentrate, Incoordination, Problem with Memory and Seizures.
Psychiatric Not Present- Anxiety, Depression and Insomnia.
Endocrine Not Present- Appetite Changes, Cold Intolerance, Decreased Sweating, Excessive Sweating, Excessive Thirst, Excessive Urination, Hair Changes, Heat Intolerance and Thyroid Problems.
Hematology Not Present- Anemia, Easy Bruising, Excessive bleeding and Gland problems.

Vitals

02/20/2018 10:26 AM
Weight: 200 lb **Height**: 66 in
Body Surface Area: 2 m² **Body Mass Index**: 32.28 kg/m²

Physical Exam

The physical exam findings are as follows:
On physical examination, she is a pleasant woman who has a clear understanding of her medical condition. She has mild paraspinal muscle spasms to palpation in her posterior cervical triangle more so on the right than on the left. Flexion and extension is full. She has pain on axial loading, but not a Lhermitte's. She also has pain on axial loading during a Spurling's maneuver, but it really only radiates to her shoulders bilaterally. She is full power throughout. She is areflexic in the upper extremities and does not have sensory changes. Regarding her lower back, she has reduced flexion and extension. She has a positive bilateral finger Fortin test more so on the left than on the right. She does have a positive Gaenslen's maneuver and a Faber sign. She does not have pain on pelvic distraction or compression. She is areflexic other than in the left patella, which is normoreflexic. She does walk with a mildly wide-based gait with an unusual posture with the knee somewhat flexed. Once again, flexion and extension of the lumbar spine is reduced. She does have pain on deep flexion and deep extension both.

William D. Smith, MD
Jason E. Garbor, MD, FACS
Stuart S. Kaplan, MD, FACS
Gregory L. Douds, MD

Western Regional Center for Brain & Spine Surgery

3061 S Maryland Pkwy Suite 200
Las Vegas, NV 89109-6227
Phone: (702) 737-1948
Fax: (702) 737-7198

Procedure Order

Ordering Site

WRCBSS Maryland Parkway
3061 S Maryland Pkwy Suite 200
Las Vegas, NV 89109-6227
(702) 737-1948
Fax: (702) 737-7198

Report Date: 02/27/2018

Patient Information

Joyce Sekera
7840 Nesting Pine Place
Las Vegas, NV 89143
(702) 467-5457
Gender: Female Date of Birth: 03/22/1956 SSN (last 4 digits)

Patient Insurance Information

Farmers Work Compensation (800) 987-1007
Group #NONE
Plan #WC10132100

Procedures Ordered

CT OF LUMBAR SPINE WITHOUT CONTRAST (72131)
Diagnosis: Back pain, sacroiliac (724.6 [M53.3) Ordered by: William D Smith, MD

X-RAY OF LUMBAR SPINE, AP, LATERAL, FLEXION, AND EXTENSION VIEWS (72110)
Diagnosis: Back pain, sacroiliac (724.6 [M53.3) Ordered by: William D Smith, MD

X-RAY OF CERVICAL SPINE, AP, LATERAL, FLEXION AND EXTENSION VIEWS (72050)
Diagnosis: Back pain, sacroiliac (724.6 [M53.3) Ordered by: William D Smith, MD

X-RAY OF ENTIRE SPINE, AP AND LATERAL INCLUDING RIGHT AND LEFT BENDING 3 FOOT STANDING VIEWS (72083)
Diagnosis: Back pain, sacroiliac (724.6 [M53.3) Ordered by: William D Smith, MD

X-RAY OF LUMBOSACRAL SPINE, AP, LATERAL AND FLEXION-EXTENSION VIEWS (72110)
Note: LATERAL VIEW OF LUMBAR SPINE X-RAY MUST INCLUDE SUPERIOR ENDPLATE OF L1 AND FEMORAL HEAD.
Diagnosis: Back pain, sacroiliac (724.6 [M53.3) Ordered by: William D Smith, MD

End of Procedures Ordered

William D Smith, MD

Tuesday, February 27, 2018

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JS661

Brand Vegas LLC
3130 S. Rainbow Boulevard, Suite 305
Las Vegas, NV 89146
(702) 538-9000

To Whom it may concern:

On Decemner 28th, 2015 Joyce Sekera was first employed by Brand Vegas as a crew member. She reamioned employed by Brand Vegas until December 10, 2016.

As a result of an incident occuring on November 4, 2016 she was unable to work from November 5, 2016 to December 10, 2016.

Joyce Sekera earned $8.25 per hour, plus commission. She worked 8 hours per day and 40 hours per week. She earned approximately $500.00 per week

Based upon the above referenced information, Joyce Sekera sustained wage losses totaling approximately $2,500.00

Warren Church Jr.

Chief Operating Officer

THE GALLIHER LAW FIRM
Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
1850 East Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Telephone: (702) 735-0049
Facsimile: (702) 735-0204
kgalliher@galliherlawfirm.com
Attorney for Plaintiff

THE GALLIHER LAW FIRM
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

DISTRICT COURT

CLARK COUNTY, NEVADA

JOYCE SEKERA, an Individual, Plaintiff, v. VENETIAN CASINO RESORT, LLC, d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; LAS VEGAS SANDS, LLC d/b/a THE VENETIAN LAS VEGAS, a Nevada Limited Liability Company; YET UNKNOWN EMPLOYEE; DOES I through X, inclusive, Defendants.	CASE NO.: A-18-772761-C DEPT. NO.: 24

PLAINTIFF JOYCE SEKERA'S FIRST SUPPLEMENTAL EARLY CASE CONFERENCE DISCLOSURE STATEMENT, LIST OF DOCUMENTS AND WITNESSES, AND NRCP 16.1(a)(3) PRE-TRIAL DISCLOSURE

COMES NOW, JOYCE SEKERA, by and through her attorneys of record, THE GALLIHER LAW FIRM, hereby submits the following First Supplement to the Early Case Conference Disclosure Statement List of Documents and Witnesses and NRCP 16.1(a)(3) Pre-Trial Disclosure, as Plaintiff intends to introduce the following documents and witnesses at the trial of this matter.

NEW ITEMS LISTED IN BOLD.

THE GALLIHER LAW FIRM
Keith E. Galliher, Jr., Esq.
Nevada Bar No. 220
1850 East Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Telephone: (702) 735-0049
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kgalliher@galliherlawfirm.com
Attorney for Plaintiff

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DISTRICT COURT

CLARK COUNTY, NEVADA

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I

LIST OF WITNESSES

1. Joyce Sekera
   c/o The Galliher Law Firm
   1850 E. Sahara Avenue, Suite 107
   Las Vegas, Nevada 89104

*Expected to testify regarding the facts and circumstances of the incident, the injuries sustained as a result thereof and the effects those injuries have had on her life.

2. Yet to be identified employees
   The Venetian Las Vegas
   c/o Royal & Miles LLP
   1522 W. Warm Springs Road
   Henderson, Nevada 89014

*Expected to testify regarding the facts and circumstances of the incident which occurred on November 4, 2016.

3. Person Most Knowledgeable and/or
   Custodian of Records
   The Venetian Las Vegas
   c/o Royal & Miles LLP
   1522 W. Warm Springs Road
   Henderson, Nevada 89014

*Expected to testify regarding the facts and circumstances of the incident which occurred on November 4, 2016.

4. Person Most Knowledgeable and/or
   Custodian of Records
   Centennial Hills Hospital
   6900 N. Durango Drive
   Las Vegas, Nevada 89149

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

5. Person Most Knowledgeable and/or
   Custodian of Records
   Shadow Emergency Physicians
   1000 River Road, Suite 100
   Conshohocken, Pennsylvania 19428

THE GALLIHER LAW FIRM
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

6. Person Most Knowledgeable and/or
   Custodian of Records
   Desert Radiologists
   2020 Palomino Lane #100
   Las Vegas, Nevada 89106

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

7. Jordan B. Webber D.C.
   Person Most Knowledgeable and/or
   Custodian of Records
   Desert Chiropractic & Rehab/Core Rehab
   10620 Southern Highlands Parkway, Suite 110-329
   Las Vegas, Nevada 89141

*It is expected that Dr. Webber will testify as a non-retained expert in his capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Webber is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, his expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. His opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. His testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering his expert opinions he will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and his respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

He will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Webber's opinions include, but

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Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

are not limited to, his education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic tests that were performed, his review of Plaintiff's medical records. In addition, Dr. Webber will testify as a rebuttal expert to any medically designated defense experts in which he is qualified.

8. Person Most Knowledgeable and/or
Custodian of Records
Las Vegas Radiology
3201 S. Maryland Parkway, Suite 102
Las Vegas, Nevada 89109

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

9. Michelle Hyla, D.O.
Person Most Knowledgeable and/or
Custodian of Records
Southern Nevada Medical Group
1485 E. Flamingo Road
Las Vegas, Nevada 89119

*It is expected that Dr. Hyla will testify as a non-retained expert in her capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Hyla is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, her expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. Her opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. Her testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering her expert opinions she will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and her respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

She will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Hyla's opinions include, but are not limited to, her education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic

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Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

tests that were performed, her review of Plaintiff's medical records. In addition, Dr. Hyla will testify as a rebuttal expert to any medically designated defense experts in which she is qualified.

10. Russell J. Shah, M.D.
Person Most Knowledgeable and/or
Custodian of Records
Radar Medical Group
10624 S. Eastern Avenue, #A-425
Henderson, Nevada 89052

*It is expected that Dr. Shah will testify as a non-retained expert in his capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Shah is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, his expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. His opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. His testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering his expert opinions he will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and his respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

He will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Shah's opinions include, but are not limited to, his education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic tests that were performed, his review of Plaintiff's medical records. In addition, Dr. Shah will testify as a rebuttal expert to any medically designated defense experts in which he is qualified.

11. Person Most Knowledgeable and/or
Custodian of Records
PayLater/WellCare Pharmacy
P.O. Box 1200
Las Vegas, Nevada 89125

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

THE GALLIHER LAW FIRM
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

12. Person Most Knowledgeable and/or
Custodian of Records
Las Vegas Pharmacy
2600 W. Sahara Avenue, Suite 120
Las Vegas, Nevada 89102

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

13. Katherine D. Travnicek, M.D.
Person Most Knowledgeable and/or
Custodian of Records
Pain Institute of Nevada
7435 W. Azure Drive, Suite 190
Las Vegas, Nevada 89130

*It is expected that Dr. Travnicek will testify as a non-retained expert in her capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Travnicek is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, her expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. Her opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. Her testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering her expert opinions she will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and her respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

She will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Travnicek's opinions include, but are not limited to, her education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic tests that were performed, her review of Plaintiff's medical records. In addition, Dr. Travnicek will testify as a rebuttal expert to any medically designated defense experts in which she is qualified.

14. Person Most Knowledgeable and/or
Custodian of Records
Valley View Surgery Center

THE GALLIHER LAW FIRM
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
702-735-0049 Fax: 702-735-0204

1330 S. Valley View Blvd.
Las Vegas, Nevada 89102

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

15. Person Most Knowledgeable and/or
Custodian of Records
Steinberg Diagnostics
P.O. Box 36900
Las Vegas, Nevada 89133

*The Person Most Knowledgeable is expected to testify regarding the care and treatment rendered to Plaintiff following the November 4, 2016 incident, which is the subject of this litigation, as well as any pre and post incident care and treatment of the Plaintiff. They are also expected to testify regarding medical causation of injury and the reasonableness and necessity of medical treatment and billing. They will also testify regarding future medical treatment and future medical expenses, if any. Additionally, the Custodian of Records is expected to testify as to the authenticity of the medical and billing records associated with Plaintiff's care and treatment.

16. Andrew Cash, M.D.
Person Most Knowledgeable and/or
Custodian of Records
Desert Institute of Spine Care
9339 W. Sunset Road, Suite 100
Las Vegas, Nevada 89148

*It is expected that Dr. Cash will testify as a non-retained expert in his capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Cash is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, his expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. His opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. His testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering his expert opinions he will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and his respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

He will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to

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have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Cash's opinions include, but are not limited to, his education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic tests that were performed, his review of Plaintiff's medical records. In addition, Dr. Cash will testify as a rebuttal expert to any medically designated defense experts in which he is qualified.

17. Willian D. Smith, M.D.
Person Most Knowledgeable and/or
Custodian of Records
Western Regional Center for Brain & Spine
3061 S. Maryland Parkway, Suite 200
Las Vegas, Nevada 89109

*It is expected that Dr. Cash will testify as a non-retained expert in his capacity as medical physicians who provided medical care to Plaintiff, following the subject incident. Dr. Cash is expected to give expert opinions regarding the treatment of Plaintiff, the necessity of the treatment rendered, the causation of the necessity for past and future medical treatment, his expert opinion as to past and future restrictions of activities, including work activities, caused by the incident. His opinions shall include the cost of past and future medical care and whether those medical costs fall within the ordinary and customary charges for similar medical care and treatment. His testimony may also include expert opinions as to whether Plaintiff has a diminished work life expectancy, work capacity, and/or life expectancy as a result of the incident.

In rendering his expert opinions he will rely upon the records of all physicians, health care providers, and experts, who have rendered opinions, medical care and treatment to Plaintiff and his respective expert opinions regarding the nature, extent and cause of Plaintiff's injuries, the reasonableness and necessity of the charges for medical treatment rendered to Plaintiff, the charges for Plaintiff's past medical care as being customary for physicians and/or health care providers in the medical community.

He will render expert opinions that all of the past and future medical care provided to Plaintiff was reasonable and necessary, that the need for said care was caused by the subject incident, that all charges were reasonable and customary, that the Plaintiff has, and will continue to have, restrictions on her activities and ability to work, that the Plaintiff will have a diminished work life expectancy and a diminished life expectancy. The basis for Dr. Cash's opinions include, but are not limited to, his education, training, and experience, the nature of the trauma Plaintiff was subjected to because of Defendant's negligence, Plaintiff's history and symptoms, any diagnostic tests that were performed, his review of Plaintiff's medical records. In addition, Dr. Cash will testify as a rebuttal expert to any medically designated defense experts in which he is qualified.

18. Marissa Freeman
8929 Monte Oro Drive
Las Vegas, Nevada 89131

***Expected to testify as to the Plaintiffs physical condition before and after the incident which occurred on November 4, 2016.**

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19. Brian Freeman
8929 Monte Oro Drive
Las Vegas, Nevada 89131
***Expected to testify as to the Plaintiffs physical condition before and after the incident which occurred on November 4, 2016.**

20. Carole Divito
7840 Nesting Pine Place
Las Vegas, Nevada 89143
***Expected to testify as to the Plaintiffs physical condition before and after the incident which occurred on November 4, 2016.**

21. Any and all witnesses named by the Defendant.

II

COMPUTATION OF DAMAGES

1. Centennial Hills Hospital	$4,454.00
2. Shadow Emergency Physicians	$1,272.00
3. Desert Radiologists	$77.00
4. Dr. Webber	$10,756.00
5. Las Vegas Radiology	$848.00
6. Dr. Hyla	$1,975.00
7. Dr. Shah	$17,613.50
8. PayLater/WellCare Pharmacy	$282.33
9. Las Vegas Pharmacy	$1,090.93
10. Dr. Travnicek	$16,000.00
11. Valley View Surgery Center	$15,489.48
12. Steinberg Diagnostics	$1,400.00
13. Dr. Cash	$1,750.00
14. Wage loss and loss of earning capacity	(To be determined)

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15. Past and future pain and suffering $350,000.00 (estimated)

III

LIST OF DOCUMENTS

1. Records and billing from Centennial Hills Hospital (Bates #JS001 to 074)
2. Billing from Shadow Emergency Services (Bates #JS075 to 076)
3. Records and billing from Desert Radiologists (Bates #JS077 to 082)
4. Records and billing from Dr. Webber (Bates #JS083 to 243)
5. Records and billing from Las Vegas Radiology (Bates #JS244 to 262)
6. Records and billing from Dr. Hyla (Bates #JS263 to 303)
7. Records and billing from Dr. Shah (Bates #JS304 to 378)
8. Billing from PayLater Pharmacy (Bates #JS379)
9. Billing from Las Vegas Pharmacy (Bates #JS380 to 381)
10. Records and billing from Dr. Travnicek (Bates #JS382 to 475)
11. Records and billing from Valley View Surgery Center (Bates #JS476 to 601)
12. Records and billing from Steinberg Diagnostics (Bates #JS602 to 608)
13. Records and billing from Dr. Cash (Bates #JS609 to 658)
14. Records from Dr. Smith (Bates #JS659 to 661)
15. Wage loss document (Bates #JS662)
16. Any and all documents disclosed by the Defendants.

IV

DEMONSTRATIVE EXHIBITS

Plaintiffs may offer at trial, certain Exhibits for demonstrative purposes including, but not limited to, the following:

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a. Actual surgical hardware, plates screws, surgical tools, and surgical equipment as used in Plaintiff's medical treatment and anticipated to be used in future treatment;

b. Demonstrative and actual photographs and videos of surgical procedures and other diagnostic tests Plaintiff has undergone and will undergo in the future;

c. Actual diagnostic studies and computer digitized diagnostic studies;

d. Samples of tools used in surgical procedures;

e. Diagrams, drawings, pictures, photos, film, video, DVD and CD ROM of various parts of the human body, diagnostic tests and surgical procedures;

f. Computer simulation, finate element analysis, mabymo and similar forms of computer visualization;

g. Power point images/drawings/diagrams/animations/story boards, of the related vehicles involved, the parties involved, the location of the motor vehicle accident and what occurred in the motor vehicle accident;

h. Pictures of Plaintiff's Prior and Subsequent to the Subject accident;

i. Surgical Timeline;

j. Medical treatment timeline;

k. Future Medical timeline;

l. Charts depicting Plaintiff's Life Care Plans;

m. Charts depicting Plaintiff's Loss of Hedonic Damages;

n. Charts depicting Plaintiff's Loss of Household Services;

o. Photographs of Plaintiff's Witnesses;

p. Charts depicting Plaintiff's Life Expectancy;

q. Story boards and computer digitized power point images;

r. Blow-ups/transparencies/digitized images of medical records, medical bills, photographs and other exhibits;

s. Diagrams/story boards/computer re-enactment of motor vehicle accident;

t. Diagrams of various parts of the human body related to Plaintiff's injuries;

u. Photographs of various parts of the human body related to Plaintiff's injuries;

v. Models of the human body related to Plaintiff's injuries;

w. Samples of a spinal cord stimulator and leads;

x. Sample of an intrathecal drug delivery system and leads;

y. Samples of the needles and surgical tools used in Plaintiff's various diagnostic and therapeutic pain management procedures

Plaintiff reserves the right to supplement these disclosures with any and all other relevant information and documents and records that come into her possession during discovery.

DATED this 12th day of July, 2018

THE GALLIHER LAW FIRM

Keith E. Galliher, Jr., Esq.
Nevada Bar Number 220
1850 E. Sahara Avenue, Suite 107
Las Vegas, Nevada 89104
Attorneys for Plaintiff

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of THE GALLIHER LAW FIRM and that service of a true and correct copy of the above and foregoing **FIRST SUPPLEMENTAL EARLY CASE CONFERENCE DISCLOSURE STATEMENT** was served on the 16th day of July, 2018, to the following addressed parties by:

_____ First Class Mail, postage prepaid from Las Vegas, Nevada pursuant to N.R.C.P 5(b)

_____ Facsimile, pursuant to EDCR 7.26 (as amended)

✓ Electronic Mail/Electronic Transmission

_____ Hand Delivered to the addressee(s) indicated

_____ Receipt of Copy on this _____ day of _____, 2018,

acknowledged by, _____

Michael A. Royal, Esq.
Gregory A. Miles, Esq.
ROYAL & MILES LLP
1522 W. Warm Springs Road
Henderson, Nevada 89014
Attorneys for Defendants

An employee of THE GALLIHER LAW FIRM