PANHANDLE ORTHOPAEDICS

12909 Panama City Beach Pwy.
**Panama City Beach, FL 32407**
850-784-7724 - Fx: 850-784-4711

710 Hospital Drive
**Crestview, FL 32539**
850-398-8480 - Fx: 850-398-8482

2401 Langley Avenue Unit B
**Pensacola, FL 32504**
850-407-7840 - Fx: 850-407-7839

## PRIOR TO SURGERY

Handle any personal/business obligations. Depending on the type of surgery, the length of time you will be incapacitated will vary. This will help make the post-op period less stressful.

Notify the office immediately if any changes in your physical exam or condition occur after your last appointment at our office. Depending on the change or condition this could affect your surgery date or outcome.

Wash with surgical soap **5** days prior to procedure. DO NOT get it on your face, hair, or eyes. Rinse off all surgical soap. DO NOT shave surgical extremity within 48 hours of procedure.

* If you take anticoagulants you must hold these prior to hospital or office surgery-Aspirin/Plavix stop **7** days prior to surgery. Coumadin stop **3** days prior to surgery. You must stop taking all non-steroidal anti-inflammatory medications which contain any of the following **7** days prior to surgery – Ibuprofen, Motrin, Aleve, Celebrex, Indocin, Mobic, Naprosyn, Garlic, Vitamin E, Voltaren gel, Flector/ Medrox patch, to include topical NSAIDs (Terocin) to the surgical area, etc. Do not drink alcohol within 24 hours of your surgery, as this will act as a blood thinner.

*Do not eat or drink after midnight the night prior to surgery. Certain medications will need to be taken with a sip of water the morning of surgery. Ask the pre-op nurse at the Surgery Center which medications to take. You may brush your teeth.

You **MUST** have a driver, to and from surgery and to and from your 1st Post Op appointment. This person **MUST** be a family member/relative, close friend. Please be sure that the person bringing you to your surgery/appointments speaks English, or have a translator available. You are **NOT** to drive while taking narcotic medications, or until released by your physician.

*Do not forget your crutches, if applicable. They do not have crutches at the surgical center, and they will not discharge you without them. **IT IS YOUR RESPONSIBILITY TO FILL ALL PRESCRIPTIONS PRIOR TO YOUR SURGERY, AND TAKE THEM WITH YOU TO THE SURGERY CENTER FOR THEM TO REVIEW.**

There will be three businesses accessing your insurance company for surgery: Panhandle Orthopaedics, Anesthesia and the Surgical Facility. In the event that you are billed through Advantage Anesthesia, LLC and this company is not a participant within your insurance plan, they will work with your carrier through appeal efforts to ensure that you are **not penalized** for our non-participating (aka out-of-network) status. If you have any questions or concerns, please contact Advantage Anesthesia directly at **1-877-360-1566.**

During the course of your surgery the need may arise for use of implants/hardware. If your insurance company is not able to pay for these implants, the surgical facility may use a company called IPG to obtain reimbursement for any implants/hardware that is not covered. For questions or concerns regarding IPG, please contact them directly **at 1-866-295-1260.**

Some surgical procedures have a "90-day global period" in which office visits are covered under your surgery fees, however any x-rays, splinting, casting, or physical therapy visits are **not** covered under this visit.

Signature _____ Date _____

Witness _____ Date _____

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## POSSIBLE SURGICAL AND ANESTHETIC COMPLICATIONS

Prior to surgery Dr. Gilmore would like all his patients to be well educated and informed prior to making the decision to proceed with surgery. Therefore, Dr. Gilmore would like to make you aware of the following possible surgical complications prior to making the decision to proceed with surgery. Complications are always unexpected, but when there are complications there is a commonly-accepted list of such complications.

Possible surgery (Open procedures and Arthroscopy procedures) risks include but are not limited to the following – deep vein thrombosis (blood clot), pulmonary embolus, infection, post operative bleeding, neurological and vascular complications, anesthetic complications, tissue death, possibility of further surgery and/or revision and actual death. Also, failing to comply with rehabilitation and therapy following surgery will likely develop complications such as decreased mobility, poor fracture healing, and decrease in function, stiffness of joint, prolonged post operative pain and inflammation, and overall potential for poor surgical results.

Specific complications following surgery for fractures include but not limited to – Nonunion or mal-union of the fracture site, angular deformity, and failure of the hardware, cast complications, and possible overgrowth /delayed growth and/or growth arrest in skeletally immature patients. Specific complications following surgery requiring prosthesis (partial or total joint replacements) include but not limited to: Lyses, loosening of the prosthesis, thigh pain, hardware pain, catastrophic failure and possible leg length discrepancies (following total hip replacements) and limb dislocations.

Possible complications from anesthesia and nerve blocks include, but are not limited to, pneumothorax, pseudo aneurysm, respiratory distress from nerve palsy, seizures, hematoma, cardiovascular collapse, spinal or epidural anesthesia, peripheral neuropathy, regional block paresthesia/hypoesthesia temporarily and/or permanently, and complex regional pain syndrome.

I have read this written informed consent, or it has been read to me, and I understand its contents. My signature below certifies that I agree to have surgery and I accept the inherent risks of commonly-accepted complications. I understand the possible risks and complications that may arise from undergoing anesthesia. And I accept those as well.

## INFORMED CONSENT FOR FREEZE DRIED OR FRESH FROZEN DONOR TISSUE FOR RECONSTRUCTIVE SURGERY

Donor tissue used to reconstruct ruptured ligaments is called an Allograft. This tissue has been taken sterilely under strictly controlled conditions. It has been tested for contamination and has been screened for transmittable diseases such as Acquired Immune Deficiency Syndrome (AIDS), Hepatitis B and C and syphilis. The tissue is fresh frozen or freeze dried to minimize the risk of rejection and stored until implantation.

The benefit of using Allograft tissue for ligament reconstruction is that it provides a method of correcting ligament instability without sacrificing the patient's own tissues. The use of Allograft tissue has the same risks that any reconstructive procedure of a ligament does, which include breaking or excessive stretching of the transplant, or loosening of the fixation. Complications which may occur postoperatively include stiffness of the joint, pain, tenderness over the point of fixation, failure of the graft to heal completely, wound breakdown or infection. If there has been extensive damage to the joint before surgery, occasional pain and swelling may continue after the joint is stabilized by surgery. If the joint is subjected to a similar type of insult that damaged the ligaments initially, then there is a good likelihood that the Allograft reconstruction of the joint will also suffer damage. Although the tissue is tested for AIDS virus antibody and antigen and found negative, there is a very small risk (1 in 1 Million) that the test is incorrect. The donor may have contracted the virus immediately prior to death, which may not allow enough time for detection of the antigen or antibody. However, the donor screening process is very rigid in order to eliminate members of high risk groups, such as known carriers, IV drug users or hemophiliacs.

I hereby certify that my physician has explained to me the advantage and disadvantages of the planned reconstructive surgery using allograft ligament tissue. Surgical alternatives, such as using my own tissue, as well as medically acceptable non-surgical alternatives, have been explained to me. I have also read this written informed consent, or it has been read to me, and I understand its contents.

____ My initials along with my signature/date below certifies that I agree to have surgery using Allograft ligament tissue.

Signature _____ Date _____

Witness _____ Date _____

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**CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS**

Controlled substance medications are very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. They are intended to relieve pain to improve function and/or ability to work, not to simply feel good. Because Dr. Gilmore is prescribing such a medication for me to help manage my pain**, I agree to the following conditions:**

I am responsible for my controlled substance medications. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I realize that surgical pain usually decreases within **three** days following surgery. After the initial prescription any prescriptions that follow will be modified and/or decreased in accordance to Dr. Gilmore's criteria.

I understand that pain prescriptions are prescribed for **short term use only, as in post-operative pain**. Long term pain medication needs, due to chronic problems and conditions in which the patient has elected not to have corrected with various treatment options, will be followed and prescribed by the primary care physician or a pain management physician. Dr. Gilmore will **not** order pain meds for long term chronic problems, or greater than 30 days after a major surgery.

I will **not** request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Gilmore while under his care. Besides being illegal to do so, is may also endanger my health. The only exception is when it is prescribed while I am admitted into a hospital or an ER visit.

**Refills of controlled substance medication**:

**A**. Refills will be made only during regular office hours, Monday through Thursday and will be called in to the pharmacy from 4:00 to 5:00 P.M. Call your pharmacy first, then the office (850) 398-8480 to request refill. If you need a prescription refilled on Friday you must call by Wednesday. Refills will **not** be made after 12:00pm on Fridays, at night, on holidays, or on weekends.

**B**. Refills will not be made if I "run out early", "lose a prescription" or "spill or misplace my medication." Refills will not be made for any stolen medication, nor will a new prescription be made to replace any medication.

**C**. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least (48) hours ahead if I need assistance with a controlled substance medication prescription.

**D**. I realize that refills will be made on a case by case basis, and that a request for a medication does not imply that I am entitled to or that any refill of prescription will be given.

I understand that I may be **drug screened** at any time, and refusal of drug screen will result in denial of further prescriptions.

It may be deemed necessary by Dr. Gilmore for me to see a medication use specialist at any time while I am receiving controlled substances**.** I understand if I do not attend this appointment that my medications may not be continued or refilled beyond a tapering dose to completion. I understand if this specialist feels I am at risk for psychological dependence that my medications will no longer be refilled. I understand that driving a motor vehicle or operating machinery will not be allowed while taking controlled substances and that my responsibility to comply with the laws of this state while taking the medication prescribed.

I understand that if I **violate any of the above conditions**, my controlled substance prescription and/or treatment may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to physicians, medical facilities, and any other appropriate authorities including law enforcement authorities.

Ultimately, I understand that the main orthopedic treatment goal is to improve my ability to function at work and school. I understand, accept, and agree that there may be unknown risk associated with long term use of controlled substances and that my physician will advise me as knowledge and training advances and will make appropriate treatment changes. I have been fully informed by Panhandle staff regarding psychological dependence which I understand is rare. I know that some persons will develop a tolerance. I do understand that I may become physically dependent on the medication if I am on the medication for several weeks. If that occurs I understand that when I stop taking the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms. I have read this contract and the same has been explained to me by Dr. Gilmore and his staff. In addition, I fully understand the consequences of violating this contract.

Signature _____ Date _____

Witness _____ Date _____

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## PATIENT EDUCATION ACKNOWLEDGEMENT FORM

I acknowledge that Michael Gilmore, M.D. / Panhandle Orthopaedics, LLC has provided the following educational information on my proposed surgical procedure/ pre and post operative care/treatment and recommendations.

I have reviewed the following educational documentation and/or office demonstration relative to my upcoming procedure: Reading Material, Any pertinent diagnostic results, models.

I have been provided educational websites to review at my leisure relative to my upcoming procedure.

## DISCLOSURE OF FINANCIAL INTEREST

You have been provided a copy of this document for informational purposes. Michael Gilmore, M.D. (or someone in the employ of Panhandle Orthopaedics) is going to refer you to an ambulatory surgical center called The Surgical Center for Excellence, LLLP, a Florida limited liability limited partnership, for the purpose of having a medical procedure.

Dr. Gilmore (or an affiliate entity) has an investment interest in The Surgical Center for Excellence. This entity is located at 202 Doctors Drive, Panama City, FL 32405. He, or someone that works with him, is recommending that you have a procedure at The Surgical Center for Excellence. Dr. Gilmore wishes to make it clear that you have the right to obtain treatment and procedures at other places in which he does not have an investment interest, at a place of your choice; however, Dr. Gilmore presently only provides surgical services at The Surgical Center for Excellence, LLLP in Panama City, FL and North Florida Surgical Center in Pensacola, FL

Should you wish to have your procedure done at another location, please be advised that you may want to contact one of the following places for assistance:

North Florida Surgical Center  Bay Medical Center  Gulf Coast Medical Center

North Okaloosa Medical Center  Northwest Florida Community Hospital  Crestview Surgical Center

____By initialing this form I am agreeing to have my proposed surgical procedure performed at **The Surgical Center for Excellence**.

Upon review of your case, a surgical procedure has been scheduled. The following information is to ensure that your surgical procedure and post-operative period go as smoothly as possible. It is the goal of Panhandle Orthopaedics to assist and encourage the best possible results through medical intervention, patient education and patient self-care.

**The Surgical Appointment** _____ **Date**_____ **Day**

**Post Operative Appointment** _____ **Date** _____ **Day**

## CANCELLATION POLICY:

It is imperative that all appointments are kept as scheduled. Should you need to cancel your surgery, you must notify Surgical Coordinator at 850-398-8480 TEN days prior to your surgery date (excluding weekends) to avoid a cancellation fee of $1,000.00 applied to your account. We will inform the surgical center upon your cancellation. If you have any questions regarding your surgical procedure please call the Surgical Coordinator at 850-398-8480.

Signature _____ Date _____

Witness _____ Date _____

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| Patient Name: | Chart Number: | Date: |
|---|---|---|

Proposed Procedure :

| Referring MD: | Date of Birth: | Age: | Sex: | Surgeon: |
|---|---|---|---|---|
| MICHAEL GILMORE M.D. | | | | MICHAEL GILMORE M.D. |

**AUTHORIZATION AND CONSENT TO SURGERY/ SPECIAL DIAGNOSTIC/ THERAPEUTIC PROCEDURES PAGE 1**

This operation or procedure, together with any different or future procedures which in the opinion of the supervising physician or surgeon may be indicated due to medical necessity, will be performed on you by the supervising physician or surgeon named above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon) together with associates and assistants, including anesthesiologists from the medical staff of the Center to whom the supervising physician or surgeon may assign designated responsibilities, or licensed medical residents in training.

The persons who perform specialized medical services such as anesthesia, or pathology are not agents, servants, or employees of the Center or your supervising physician or surgeon. There may also be student nurses or student surgical techs involved in your care who are not agents, servants or employees of the Center or your supervising physician or surgeon. They are independent contractors and the Center is not responsible or liable for their acts or omissions. If there are students present the day of your procedure, you have the right to choose to not have them involved in your medical care.

The Center maintains personnel and facilities to assist your physician and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks, unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

I authorize my doctor to perform any other indicated surgery/medical procedure that, in his/her judgment is medically necessary for my well being, including but not limited to re-breaking a bone to align it and restore it to the best possible function. In some cases, my doctor will not be able to identify prior to surgery just what the additional surgery/ medical procedure might be. I understand this. If there are surgeries or procedures that I do not want performed, I have informed my doctor. Operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or refuse any proposed operation or procedure at any time prior to the performance. By signing this document, you certify that your supervising physician or surgeon has fully advised you of these matters.

You authorize the pathologist to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operation or procedure set forth above. You authorize the Center and your physician or other persons at the direction of your physician to photograph and use the negatives or prints from such photographs for purposes related to your health care.

You authorize the Center to transfer you to another health care facility should your physician determine it to be necessary. In addition you also consent to the release for your medical records to such facility or other treating doctors. In the event of an emergency or transfer to a higher level of care, you will authorize blood or blood products to be given to you. If you choose to not receive blood or blood products, you have informed staff.

In the very rare event that a facility employee or health professional has accidental exposure to my blood or other body fluids (for example, they are stuck by a needle with my blood on it), I authorize the Facility to draw my blood for testing for the presence of HIV/AIDS or hepatitis. I know I will not be charged for this testing. If tests show the presence of these illnesses, the results will be forwarded to my personal physician for confidential medical follow-up and treatment if needed in order to protect my health and the health of my family. Additionally, the Facility will offer medical care to the involved employee or healthcare professionals. All tests and test results will be handled in a strictly confidential manner.

I consent to the administration of anesthesia/sedation and to the use of such anesthetics as may be deemed advisable. The alternative choices of anesthesia available to me have been explained and I have had an adequate opportunity to discuss the associated risks and hazards. I understand that any type of anesthesia carries substantial risk and hazards such as pneumothorax, pseudo aneurysm, and respiratory distress

from nerve palsy, seizure, hematoma, cardiovascular collapse, spinal or epidural anesthesia, peripheral neuropathy, and complex regional pain syndrome.

**AUTHORIZATION AND CONSENT TO SURGERY/ SPECIAL DIAGNOSTIC/ THERAPEUTIC PROCEDURES PAGE 2**

Your signature below certifies (1) that you have read and understood the information provided in this form, (2) that the procedure set forth above has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure, (5) that you accept any substantial and significant risks of the procedure, and (6) that you authorized and consent to the performance of the procedure.

Patient Signature _____ Date _____

Patient is unable to sign as: Patient is a minor: _____ years of age. Patient is unable to sign because _____

Closest Relative/ Legal Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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## NORMAL FINDINGS FOLLOWING SURGERY

Dr. Gilmore would like all his patients to be educated and informed of findings considered normal following surgery or a fracture. Along with these findings he would also like to recommend treatment options for the following:

Swelling/Edema/Pain is expected – elevate the extremity above the level of the heart and apply ice/cool packs 30 minutes per hour, this is to control swelling which is a major contributor to increased pain... This may be performed if a splint is present – do not get the splint wet; place a towel over the splint and then the ice/cool pack.

Pain meds may not completely stop the pain. They are prescribed to keep the pain at a manageable level. Take your medications as prescribed without "breaks" between. Alternate your pain medication and your anti-nausea medications as directed (every 2-3 hours). Complete all antibiotics as directed. Begin taking oral pain meds immediately following surgery even though a nerve block has been performed during surgery. The combination of the two will provide more consistent pain control.

Do not remove the surgical dressing for 1-2 days after surgery or until your 1st post op visit at the office. The area must then be kept clean and dry. Some redness and drainage may be noticed following surgery. If a brace/splint/etc. is ordered it must be worn as instructed by the MD.

Numbness/tingling/burning is expected to the affected extremity following surgery or fracture due to trauma to the nerve endings and swelling.

Do not submerge the wound in water or bathtub. Do not get in bathtub. You will need to "sponge bathe" if necessary until otherwise directed by staff at your 1st post operative visit.

You may feel dizzy, lightheaded, sleepy, nauseous, or even vomit after surgery. Do not be alarmed (if vomiting doesn't stop after 8 hours, call nurse line) Do not make any sudden movements, or stand quickly, as you may fall. Have a family member assist for basic needs.

Do not make sign any consent forms for 24 hours after surgery due to anesthesia.

Your **Physician** will contact you after surgery to address any further questions from the day of surgery.

Physical therapy & rehabilitation may begin as soon as 1-2 days post surgery or may be delayed **based on MD determination.** Patient is expected to fully comply with post operative instructions and rehab protocols for optimal recovery.

*Notify office immediately of the following – Temperature greater than 101.5 orally, large amount of foul smelling drainage, excessive bleeding, incisions which have opened (popped sutures), intolerable pain not decreased by the pain medications and other above mentioned interventions, deep blue/purple/black discoloration to the digits of the affected extremity and/or extremely cold digits.*

***OFFICE CONTACT INSTRUCTIONS***

If you believe you are experiencing a Medical Emergency outside of normal business hours (Monday through Friday 8 AM-5PM Central Standard Time), please dial 911 or go to the nearest emergency room. If you have any questions or concerns please call the main office at (850) 398-8480 Monday through Friday 8 AM-5PM Central Standard Time, for further instructions.

Signature _____ Date _____

Witness _____ Date _____

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# PATIENT PHOTOGRAPH RELEASE FORM

I, _____, hereby grant permission to Panhandle Orthopaedics, LLC and Dr. Michael Gilmore, to utilize a photograph of me in any marketing or instructional materials of Panhandle Orthopaedics, including use on the Panhandle Orthopaedics internet website and/or Facebook® page. I understand that my face will not be revealed, nor my name, nor any other information that could reasonably identify me. I understand that this consent is limited to photographs of only the area of my surgery at Panhandle Orthopaedics. I acknowledge Dr. Gilmore's right, which may be delegated to a graphics professional, to adjust my photograph's appearance as necessary in his sole discretion. I also acknowledge that Dr. Gilmore may choose not to use my photograph at this time, but may do so at his discretion at a later date. I also understand that once my image is posted on Dr. Gilmore's internet web site, the image can be downloaded by any computer user, which is beyond the control of Dr. Gilmore, and I will hold him and Panhandle Orthopaedics harmless from any potential liability due to such use or download. I understand that I will not be compensated in any manner for the use of my photograph as described in this release.

I hereby knowingly, freely & voluntarily consent to the use of my photograph as stated above unless or until I revoke this consent in writing.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Signature | Parent/Guardian Signature (If under age of 18) | Witness Signature |
| _____ | _____ | _____ |
| Printed Name | Parent/Guardian Printed Name (If under age of 18) | Witness Printed Name |
| _____ | _____ | _____ |
| Date | Date | Date |

_____
Address

_____
Parent/Guardian Address (If under age of 18)

To revoke this consent please write to:

_____
Dr. Michael Gilmore
710 Hospital Dr.
Crestview, FL 32539

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# DRIVING AFTER SURGERY

Please be aware that driving is NOT recommended immediately after surgery and for a determined period thereafter. It is important to remember that your affected limb will be immobilized, painful, stiff, and weak, and thus more difficult to use at your normal functioning level. In addition, you may be prescribed medications that affect your ability to safely operate a vehicle.

While some people may be able to compensate better than others, it has been found in multiple scientific studies that reaction times and brake response times are significantly decreased in all patients who have undergone both upper limb and lower limb surgeries. Therefore, it is the recommendation of the practice that you refrain from driving until adequate healing has occurred and you have been cleared by Dr. Gilmore to drive.

Risks of driving prematurely include inability to control the vehicle resulting in an accident with or without another individual, re-injury to the operative limb, inadequate healing or prolonged healing time, excessive drowsiness and impaired judgment while driving as a side effect to the medication.

Please note that every patient is unique and the decision of whether you are ready to return to driving depends on many factors. While we understand every patient is eager to drive and become independent again, you may require additional time to gain your ability to safely operate a vehicle, particularly if you have another underlying medical condition or operate a vehicle with a manual transmission. At minimum, you can expect to have the following recovery periods for the specific surgeries listed below. Again, please remember these are general guidelines and your specific situation may require additional recovery time.

IMPORTANT: REGARDLESS OF THE TIMEFRAMES BELOW, PLEASE KEEP IN MIND THAT YOU MAY NOT BE RELEASED TO DRIVE FOR 10-14 WEEKS POST OP - DEPENDING ON YOUR SURGICAL PROCEDURE.

| | |
|---|---|
| *Knee Arthroscopy (Excluding ACL)* | *4-6 weeks* |
| *Right ACL Reconstruction* | *6 weeks* |
| *Left ACL Reconstruction* | *2 weeks* |
| *Bunion Surgery* | *6 weeks* |
| *Lower Extremity Fracture* | *12-18 weeks* |
| *Right Ankle Fracture* | *9 weeks* |
| *Right Knee Arthroplasty* | *6-8 weeks* |
| *Left Knee Arthroplasty* | *2-4 weeks* |
| *Right Hip Arthroplasty* | *6-8 weeks* |
| *Upper Extremity Injury Requiring Immobilization* | *4-6 weeks* |

I have reviewed the above recommendations and understand them. I understand that these recommendations are for my safety and for the safety of others, and until I have been evaluated and cleared by my physician to do so, I am not safe to operate a vehicle. My signature below certifies that I will not drive until recommended by Dr. Gilmore, and I accept the risks associated if I choose not to follow these recommendations. I understand that it is my responsibility to evaluate my safety level after being cleared to drive from a medical standpoint by my physician, and that I should refrain from driving until I feel safely able to do so.

Signature _____ Date _____

Witness _____ Date _____