



**Weill Cornell Medicine**  
Otolaryngology  
Head & Neck Surgery

Vikash K. Modi, M.D., FAAP

**IN-NETWORK SURGICAL FINANCIAL POLICY**

To Whom It May Concern,

Patient Name: MOOLANI, CAMDEN DOB: 10/19/2014  
Date of Surgery: 12/13/2017 Name of Surgeon: DR. VIKASH K. MODI

My signature below indicates my understanding and agreement to the following:

1. We are aware that in using this facility's service(s), we are utilizing our in-network benefits, based upon the policy and limitations of our insurance plan, and the current active insurance information has been given to this facility to process our services.
2. We are aware that will be held responsible for any balance, which may include any unsatisfied in-network deductible and in-network co-insurance after the insurance covers the allowed payment(s).

***Should you have any further inquiries about your policy and coverage, kindly contact your insurance carrier to answer these questions in detail.*** The hospital and anesthesia charges are billed directly by the facility. If there are any questions or concern in reference to this matter, it should be addressed to the insurance company.

Our current insurance carrier is under (insurance name) Meritain Health (An Aetna Company)  
ID# 5094453290 has been provided to the concerned parties. ***Should our insurance policy be terminated, or should we change insurance carrier prior to the date of surgery, we are aware that it is our responsibility to provide the updated insurance information in writing so that the appropriate financial arrangements can be made.***

**NOTE: THIS FORM HAS TO BE COMPLETED THOROUGHLY WITH ALL THE INFORMATION AND SIGNATURES REQUESTED.**

Dana Moolani  
Patient **or** Parent/Guardian Name (Please print)

Mother  
Relationship to Patient

[Signature]  
Patient **or** Parent/Guardian Signature

12/28/17  
Date


**NewYork-Presbyterian**


MOOLANI, CAMDEN

74418700

10/19/2014

MALE

**CONSENT FOR SURGICAL OR  
OTHER INVASIVE PROCEDURES**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

I authorize VIKASH K. MODI (MD/NP/PA/\_\_\_\_) (other) and NewYork-Presbyterian Hospital (NYP) and its staff to perform the following surgical/invasive procedure.

**Procedure Side, Site and Level – Check applicable box(es): (No acronyms or abbreviations except for spinal levels)**

☐ LEFT Side; ☐ Bilateral; ☐ RIGHT Side; ☒ N/A (explain)

☐ Spinal levels \_\_\_\_\_ ☐ Digit(s) \_\_\_\_\_

Procedure: ADENOIDECTOMY

**My signature below means that:**

- I understand the following information which has been explained to me:
  - The nature and purpose of the surgery or procedure and the medical risks and benefits of the surgery or procedure.
  - The likelihood of achieving the treatment goals.
  - The potential problems that might occur during recuperation.
  - Any other reasonable treatment choices including no treatment and the medical risks and benefits.
  - The practice of medicine is not an exact science and no guarantee has been made to me about the outcome of the surgery or procedure.
  - That tissue, organ or body parts removed during surgery will be used for medical diagnosis and thereafter any remaining tissue, organs or body parts for the advancement of medical science.
  - There are medical risks and benefits of anesthesia that will be explained to me by the person or team providing the anesthetic.
- I have had the chance to ask questions and my questions have been answered to my satisfaction. I consent to the procedure described above.

By initialing below, I agree to allow:

[Signature] A surgical product representative to be present.

[Signature] Approved visitors to be present.

[Signature] Photography and/or filming for internal medical study/education or performance improvement purposes.

X [Signature] X Dana Moolani X Mother 12/06/17 Time: 10:37 AM/PM  
 (Patient/Health Care Agent (HCA)/ (Printed Name) (Relationship to Patient) mo./day/year  
 Guardian/Family Signature/Verbal Consent) (date)

X [Signature] X Dawn See X Colleague 12/06/17 Time: 10:39 AM/PM  
 (Witness confirming Patient/HCA/ (Printed Name) (Relationship to Patient) mo./day/year  
 Guardian/Family Signature/Verbal Consent) (date)

☐ Check this box if telephone/verbal consent. Print the name/relationship of the person consenting verbally in the above appropriate spaces.

☐ Check this box if an interpreter was involved; Interpreter Name: \_\_\_\_\_ Code: \_\_\_\_\_

If the patient is under 18, obtain permission from parent or legal guardian, unless the patient is married or a parent.

**Correct Surgery/Procedure, Site/Side Verification, Attending Physician Attestation of Informed Consent:**

(To be completed by Attending MD/appropriately credentialed practitioner performing the surgery/procedure on day of procedure or 24 hours prior to procedure for inpatients.)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_ AM/PM

☐ LEFT side; ☐ Bilateral; ☐ RIGHT side; ☐ N/A (explain)

☐ Spinal Level(s) \_\_\_\_\_ ☐ Digit(s) \_\_\_\_\_

Patient/HCA/Guardian/Family (Signature) \_\_\_\_\_

Nurse (Signature) \_\_\_\_\_ Nurse (Print Name) \_\_\_\_\_

Attending MD/Appropriately Credentialed Practitioner (Signature) \_\_\_\_\_ (MD/NP/PA/\_\_\_\_)

Attending MD/Appropriately Credentialed Practitioner (Print Name) DR. VIKASH K. MODI ID Code 7592M

☐ Check this box if interpreter was involved. Interpreter Name \_\_\_\_\_ Code \_\_\_\_\_

**A DOCUMENTED TIME-OUT MUST BE PERFORMED**



FOR PATIENT'S PARENTS / LEGAL GUARDIAN: PLEASE NOTE THE DUE DATE.

 **New York-Presbyterian**

MOOLANI, CAMDEN

74418700

10/19/2014

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**CONSENT FOR SURGICAL OR  
OTHER INVASIVE PROCEDURES**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

**COMPLETE THIS SECTION FOR CONSENT FOR SCHEDULED OVERLAPPING SURGERY**

My surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery but may not be present for my entire surgery. My surgeon has also informed me that she/he will supervise a surgical team which may include another attending surgeon, a surgery fellow and surgery residents and that some members of the surgical team will perform parts of my surgery. I understand that my surgeon or another qualified surgeon will be immediately available should the need arise during my surgery. My surgeon has answered all my questions about overlapping surgery and I give my consent.

**THIS SECTION IS NOT APPLICABLE FOR THE SURGERY.**

(Patient/Health Care Agent (HCA)/  
Guardian/Family Signature/Verbal Consent)

(Printed Name)

(Relationship to Patient)

mo./day/year  
(date)

Time: \_\_\_\_\_ AM/PM

**PLS. SIGN BLOOD TRANSFUSION SECTION BELOW.**

**CONSENT/REFUSAL FOR ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS\***

**My signature below means that:**

1. I understand the information explained to me including:

- The nature and purpose of the blood and blood products that may be needed.
- The risks of receiving blood and blood products including but not limited to a blood reaction or a blood-transmitted disease and the benefits of the blood and blood products.
- The reasonable foreseeable risks and benefits of the alternatives, including the risks of not receiving blood products.
- No guarantee has been made about the outcome of receiving blood and blood products.

2. I have had the chance to ask questions and my questions have been answered to my satisfaction.

I ☒ will ☐ will not accept blood and blood products\* during my Hospital Stay, Course of Treatment or Surgery/Procedure.

Reason(s) for refusing blood and blood products \_\_\_\_\_

X

(Patient/Health Care Agent (HCA)/  
Guardian/Family Signature/Verbal Consent)

X

(Printed Name)

X

(Relationship to Patient)

12 / 6 / 17  
mo./day/year  
(date)

Time: 10:41 AM/PM

3. Please check the boxes below as applicable:

☐ Check this box if telephone consent

☐ Check this box if an interpreter was involved. Interpreter Name: \_\_\_\_\_ Code: \_\_\_\_\_

I attest that the consent for blood administration has been obtained.

Attending/Appropriately Credentialed Practitioner (signature) \_\_\_\_\_ (MD/NP/PA/)

Print Name: DR. VIKASH K. MODI ID Code: 7592M Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
mo./day/year

If patient is under 18 years of age, obtain permission from parent/legal guardian, unless the patient is married or a parent.

\* "Blood and Blood Products" include red cell, white cell, platelet, cryoprecipitate and/or factor concentrates

PLS. EMAIL THESE FORMS TO ENA2001@MED.CORNELL.EDU OR FAX TO (646) 962-0128 of 2

FOR PATIENT'S PARENTS / LEGAL GUARDIAN: PLEASE NOTE THE DUE DATE.

☒ **NewYork-Presbyterian**

☒ The University Hospital of Columbia and Cornell



50705

MOOLANI, CAMDEN

74418700

10/19/2014

MALE

**PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

**GENERAL PATIENT INFORMATION (PEDIATRIC PATIENTS NEWBORN - 18 YEARS)**

Date: 12/06/17

Time: 10:42 ☒ AM ☐ PM

Name: Camden Moolani

Nickname: Cam

Age: 3 Sex: ☒ Male ☐ Female

Date of Birth: 10/19/2014

Legal Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Mother's Full Name: Dana Moolani

Father's Full Name: Karim Moolani

Home Phone #: (202) 276-2191

Work Phone #: (203) 542-4014 Cell Phone #: (917) 292-8722

Language(s) Spoken: English

Translator: \_\_\_\_\_

Religion: Jewish

Any special religious needs: \_\_\_\_\_

Pediatrician: Dr. Mishualla

Pediatrician Phone #: (888) 603-0993

Birth weight: 7 lbs 9 oz kg

Current weight: 35 lbs. kg

Does your child have any allergies? ☐ NO ☒ YES ☐ FOOD ☒ DRUG ☐ LATEX ☐ OTHER \_\_\_\_\_

ALLERGY	REACTION
<u>Amoxicillin</u>	<u>Rash</u>

Please ☒ the following that apply:

Does your child have:

Hearing Aid..... ☒ No ☐ Yes  
Eye Glasses..... ☒ No ☐ Yes  
Contacts..... ☒ No ☐ Yes  
Loose Teeth/ Chipped Teeth..... ☒ No ☐ Yes  
Crutches..... ☒ No ☐ Yes  
Wheelchair..... ☒ No ☐ Yes  
Gastric Tube..... ☒ No ☐ Yes  
Tracheostomy..... ☒ No ☐ Yes  
Oxygen/ oximeter..... ☒ No ☐ Yes  
Other..... ☒ No ☐ Yes

Does your child need help with activities of daily living? ☒ No ☐ Yes

Walking..... ☒ No ☐ Yes  
Dressing..... ☒ No ☐ Yes  
Eating..... ☒ No ☐ Yes  
Transfer..... ☒ No ☐ Yes  
Moving from Bed to Chair..... ☒ No ☐ Yes  
Bedridden..... ☒ No ☐ Yes

How do you transport your child?

☒ Stroller ☐ Wheelchair ☐ Ambulatory ☐ Carried

PLEASE LIST ALL MEDICATION (INCLUDE ALL OVER THE COUNTER/ EYE DROPS/ HERBS) THAT YOUR CHILD IS CURRENTLY TAKING.

Is your child on aspirin? ☒ No ☐ Yes

Is your child taking any anticoagulation (Warfarin/ enoxaparin sodium/ heparin)? ☒ No ☐ Yes

Medication	Dose	How Often?	Last Given	Medication	Dose	How Often?	Last Given

PLS. EMAIL THESE FORMS TO ENA2001@MED.CORNELL.EDU OR FAX TO (646) 962-0121



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**PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PAST MEDICAL HISTORY (include any chronic illnesses) / HOSPITALIZATIONS

LIST PRIOR SURGERY/ PROCEDURES

Circumcision Correction

COMPLICATIONS (if any)

None

What previous anesthesia has your child had?

☐ None

☒ General

☐ Regional

☐ Spinal

☐ Epidural

☐ Local

Please list any complications with anesthesia

None

Any family problems with anesthesia?

None

Was your child ever:

Treated in an intensive care unit? ☒ No ☐ Yes If yes, when & why?

Seen in an Emergency Room in the last 3 months? ☐ No ☒ Yes If yes, when & why? 10/18/14 where? NYP

**SOCIAL INFORMATION:**

Who does patient live with? Mom & Dad

Are parents: ☒ married ☐ divorced ☐ separated

Do parents live together? ☐ No ☒ Yes

If parents are divorced/ separated, is other parent involved? ☐ No ☐ Yes

What type of home do you live in? ☒ Apartment ☐ House

Are there any stairs? ☒ No ☐ Yes How many? 1

Are there any pets in the home? ☐ No ☒ Yes

If yes, what type? Dog

Is there any Home Care Agency involved with your child? ☒ No ☐ Yes If yes, name of agency:

Contact Person: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number (if known): \_\_\_\_\_

Does your child attend any special programs (i.e. Down's, Early Intervention)? ☒ No ☐ Yes If yes, name of program:

What grade is your child in? Nursery school Name of School: Temple Emma - El School Phone Number: (212) 507-9531

Guidance Counselor: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**NUTRITION:**

Patient's usual diet: Chicken, fish, red meat, fruits, vegetables

Formula (type): \_\_\_\_\_ Amount per feeding: \_\_\_\_\_ How many feedings per day? \_\_\_\_\_ Length of feeding time? \_\_\_\_\_

☐ Breast ☐ Bottle ☐ Cup ☐ Baby Food ☐ Table Food

Appetite: ☒ Good ☐ Fair ☐ Poor

Does your child have difficulty swallowing/ sucking?

☒ No ☐ Yes

Has your child eaten less than half of their usual meal/ snack in the last 3 days?

☒ No ☐ Yes

Has your child experienced any unexplained weight loss?

☒ No ☐ Yes

Have you been told that your child is growing slower than expected?

☒ No ☐ Yes

Does your child have any wounds that have not healed?

☐ No ☐ Yes

\*If yes to any of above the nurse will notify physician to determine need for further assessment.

MD notified: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_ AM/PM

Does your child:

use a pacifier?

☒ No ☐ Yes, specify \_\_\_\_\_

have a security object (i.e. blanket)?

☒ No ☐ Yes, specify \_\_\_\_\_

have any special bedtime/ nap needs?

☒ No ☐ Yes, specify \_\_\_\_\_

have a favorite activity/ toy?

☒ No ☐ Yes, specify \_\_\_\_\_

participate in sports/ hobbies?

☐ No ☒ Yes, specify Soccer, swimming, music



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IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

**PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE**

**BIRTH HISTORY (complete only if child less than 6 years of age):**

Hospital where child was born: Mount Sinai West

Number weeks gestation: 39

Complications during pregnancy/ delivery? No

☒ Vaginal ☐ C- Section (reason for C-section) \_\_\_\_\_

Did your child at birth:

Have a period of breath holding? ☒ No ☐ Yes  
 Have a breathing tube? ☒ No ☐ Yes  
 Have trouble breathing through the nose? ☐ No ☐ Yes  
 Appear yellow (jaundice)? ☒ No ☐ Yes

Have a blood transfusion? ☒ No ☐ Yes  
 Appear blue ("blue baby")? ☒ No ☐ Yes  
 Have any feeding problems? ☒ No ☐ Yes  
 Other (specify): \_\_\_\_\_

**DEVELOPMENTAL DATA (complete based on your child's current age):**

0 -6 Months	No	Yes	7 -15 Months	No	Yes	16 -24 Months	No	Yes
Head Control			Sits Alone			Obeys single step commands		
Visually follows objects			Crawls			Vocabulary of 10 words		
Lifts head when in prone position			Babbles/ utters sounds			Climbs stairs		
Smiles			Waves good- bye			Knows simple body parts		
Reaches			Pulls to standing position			Uses utensils		
Coos						Scribbles		
Looks at own hands								
Turns to parent's voice								
24 Months - 3 Years	No	Yes	3 -5 Years	No	Yes	Special Concerns	No	Yes
Helps get self dressed		<input checked="" type="checkbox"/>	Dresses self	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Do you have any special concerns about your child's development? If yes, explain	<input checked="" type="checkbox"/>	
Able to wash and dry own hands		<input checked="" type="checkbox"/>	Prepares own cereal	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Able to draw in a straight line		<input checked="" type="checkbox"/>	Able to copy a circle		<input checked="" type="checkbox"/>			
Combines words		<input checked="" type="checkbox"/>	Know to count to 10		<input checked="" type="checkbox"/>			
Jumps up vertically		<input checked="" type="checkbox"/>	Speaks in full sentences		<input checked="" type="checkbox"/>			
Throws ball		<input checked="" type="checkbox"/>	Hops on one foot		<input checked="" type="checkbox"/>			
Words understandable to strangers		<input checked="" type="checkbox"/>						

**HEART:**

Does your child have:

Heart disease? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 Heart murmur? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 Chest pain? ☒ No ☐ Yes What usually causes the pain? \_\_\_\_\_ How often? \_\_\_\_\_  
 Mitral valve prolapse? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 Irregular heartbeat? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 Rheumatic fever? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 A pacemaker? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 High blood pressure? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_  
 High cholesterol/ lipids? ☒ No ☐ Yes If yes, please explain \_\_\_\_\_

Have you ever been told your child needs to take antibiotics prior to a procedure/ dental work? ☒ No ☐ Yes

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**PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

**BREATHING:***Does your child:*

- |  |  |   |
|--|--|---|
| Get short of breath?   | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have asthma or wheezing?                                       | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have BPD (bronchopulmonary dysplasia)?                         | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have a productive cough?                                       | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have a history of pneumonia?                                   | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have a history of RSV or bronchiolitis?                        | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Does your child snore?   | <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes |
| Has your child had a recent cough or cold in the past 2 weeks? | <input type="checkbox"/> No            | <input type="checkbox"/> Yes            |

If yes, for how long? \_\_\_\_\_

If yes, when? \_\_\_\_\_

If yes, MD notified: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time: \_\_\_\_\_ AM/PM

*Does your child have:*

- |  |                             |   |
|--|-----------------------------|---|
| Difficulty breathing during sleep?   | <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| Restless sleep?  | <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| Breathe through his/her mouth when awake?  | <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| Have you observed symptoms of apnea?   | <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| Have you observed sweating while child sleeps?   | <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| Do you any family history of obstructive sleep apnea, sudden infant death syndrome, or apparent life threatening events? | <input type="checkbox"/> No | <input type="checkbox"/> Yes            |

**DIGESTION/ ELIMINATION:***Does your child have:*

- |   |  |   |
|---|--|---|
| Chronic stomach ache/pain                 | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Reflux (GERD)?                            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Colitis?                                  | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Diarrhea frequently?                      | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Constipation frequently?                  | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Urinary tract infections/kidney problems? | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| A stoma?                                  | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| An umbilical, inguinal, or hiatal hernia? | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| A diaper rash?                            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Nausea?                                   | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Is your child toilet trained?             | <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes |
| Last bowel movement _____                 |  |   |

If yes, how do you treat it? \_\_\_\_\_

If yes, for how many days? \_\_\_\_\_

If yes, term used: potty**MUSCULOSKELETAL/ SKIN:***Does your child:*

- |   |  |   |
|---|--|---|
| Move all extremities without difficulty?                | <input type="checkbox"/> No            | <input checked="" type="checkbox"/> Yes |
| Have chronic muscle/ joint pain?                        | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have any weakness in arms or legs?                      | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have any areas of skin redness/ rash or skin breakdown? | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have any bone fractures?                                | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |
| Have scoliosis?   | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes            |

**ENDOCRINE DISEASE:***Does your child have:*

- |                                 |  |                              |
|---------------------------------|--|------------------------------|
| Diabetes?                       | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hypoglycemic (low blood sugar)? | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| Metabolic disease?              | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |
| Thyroid disease?                | <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes, specify: \_\_\_\_\_



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MALE

**PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

**NEUROLOGIC:**

Has your child had:

Stroke? ☒ No ☐ Yes  
Seizures? ☒ No ☐ Yes  
Learning disabilities? ☒ No ☐ Yes  
Dizziness? ☒ No ☐ Yes  
Difficulty seeing? ☒ No ☐ Yes

Headaches? ☒ No ☐ Yes  
Fainting spells? ☒ No ☐ Yes  
Speech difficulties? ☒ No ☐ Yes  
Hearing loss? ☒ No ☐ Yes

Has your child ever been diagnosed with a genetic or chromosomal syndrome? ☒ No ☐ Yes If yes, specify \_\_\_\_\_

**CANCER:**

Has your child:

Been diagnosed with cancer? ☒ No ☐ Yes If yes, specify \_\_\_\_\_  
Received radiation/ chemotherapy? ☒ No ☐ Yes If yes, last treatment \_\_\_\_\_  
Placed on isolation / special precautions? ☒ No ☐ Yes If yes, specify \_\_\_\_\_

**COMMUNICABLE DISEASES:**

Has your child been exposed within the last 3 weeks to:

Chicken pox? ☒ No ☐ Yes  
Measles? ☒ No ☐ Yes  
Tuberculosis? ☒ No ☐ Yes

Mumps? ☒ No ☐ Yes  
Hepatitis? ☒ No ☐ Yes

Are your child's immunizations up to date? ☐ No ☒ Yes If no, explain \_\_\_\_\_

**BLOOD/ TRANSFUSIONS:**

Does your child have?

Bleeding problems? ☒ No ☐ Yes  
Sickle cell trait/ disease? ☒ No ☐ Yes

Bruise easily? ☒ No ☐ Yes  
Anemia? ☐ No ☒ Yes

Do you refuse blood transfusions? ☐ No ☐ Yes  
Has your child ever had a transfusion reaction? ☒ No ☐ Yes

**PARENT/ GUARDIAN SIGNATURE:** \_\_\_\_\_

DATE: 12 / 06 / 2017

Time: 10:48 AM/PM

**TO BE COMPLETED BY R.N. (If interviewed prior to day of surgery)**

**METHOD OF INTERVIEW:**

☐ Face to Face ☐ Telephone  
☐ Patient ☐ Parent/ Legal Guardian

**INFORMANT:**

**DIAGNOSIS:** \_\_\_\_\_

**PROCEDURE:** \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ TIME: \_\_\_\_\_ AM/PM

T \_\_\_\_\_ °C P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ Ht \_\_\_\_\_ cm Wt \_\_\_\_\_ kg

Form Reviewed by \_\_\_\_\_

RN

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature

TIME: \_\_\_\_\_ AM/PM

Print Name

ID Code: \_\_\_\_\_



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51187

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74418700

10/19/2014

MALE

**HOME MEDICATION LIST: AMBULATORY**

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

Date: 12 / 06 / 2017

Information Source: ☐ Patient ☐ Spouse ☒ Family member/Other Mother ☐ Medications brought from home

List only medications patient is currently taking at time of visit.

Allergies: <input type="checkbox"/> None <input type="checkbox"/> Latex <input checked="" type="checkbox"/> Other					
<u>Amoxicillin (Pash)</u>					
Please list below all of the prescription and non-prescription medications including herbals, vitamins, and nutritional supplements.					
<input checked="" type="checkbox"/> Patient does not report taking any medications at home. <input type="checkbox"/> Patient/Family unable to provide medication information.					
Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

**New Medications**

Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

**Stop Taking**



Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

Form completed by:

Print Name

Circle Appropriate (MD / RN / PA / NP / RPH)

Print Name

Circle Appropriate (MD / RN / PA / NP / RPH)

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CHART COPY

**PRE-SURGICAL BLEEDING HISTORY QUESTIONNAIRE**

PATIENT'S NAME: MOOLANI, CAMDEN DATE OF BIRTH: 10/19/2014  
74418700

MOTHER'S FIRST NAME: Dana FATHER'S FIRST NAME: Karim

**I. PERSONAL HISTORY:**

- Y ☒ N 1) Has the patient ever had surgery, stitches for trauma or a broken nose?
- Y ☒ N 2) If YES, did the patient experience **excessive bleeding** during or after the procedure?  
What was the procedure? \_\_\_\_\_
- Y ☒ N 3) Does the patient bruise easily, compared to normal?
- Y ☒ N 4) If the patient is a male, was there **excessive bleeding** after circumcision?
- Y ☒ N 5) Has the patient had frequent nosebleeds?
- Y ☒ N 6) Has the patient bleed excessively after tooth extractions, wisdom tooth surgery or with loss of baby teeth? NA
- 7) Is the patient taking any of the following?
- |   |   |                                    |
|---|---|------------------------------------|
| A) Aspirin  | Y | <input checked="" type="radio"/> N |
| B) Ibuprofen Products<br>(ie. Motrin, Advil, etc) | Y | <input checked="" type="radio"/> N |
| C) Antihistamines                                 | Y | <input checked="" type="radio"/> N |
| D) Fish Oil                                       | Y | <input checked="" type="radio"/> N |
- Y ☐ N 8) Is there any history of heavy menstrual periods? NA

**II. FAMILY HISTORY:**

- Y ☒ N 1) Are there women in your family (mother, sister, aunt, grandmother...) who have had **heavy monthly periods requiring either iron therapy or transfusions**?
- Y ☒ N 2) Is there anyone in the family with a history of **frequent nosebleeds** judged to be **severe or requiring transfusions**?
- Y ☒ N 3) Is there anyone in your family who bled **heavily** after tooth extractions, wisdom tooth surgery, or loss of baby teeth?
- Y ☒ N 4) Has anyone in your family required a blood transfusion? Who? \_\_\_\_\_  
Reason: \_\_\_\_\_
- Y ☒ N 5) Has anyone in the family been called a "free bleeder"?
- Y ☒ N 6) Has anyone in your family ever bled **excessively** after tonsil surgery, childbirth, or other surgery?
- Y ☒ N 7) Is there anyone in your family with blood disorder such as, Hemophilia, Von Willebrand disease, lower platelets, or ITP?  
Who? \_\_\_\_\_  
Diagnosis? \_\_\_\_\_

**III. ACTION PLAN:**

- 1) If ALL answers to the above questions are NO, obtain **CBC and PLATELETS** only.
- 2) If Part I, Question 2 answer is YES, and all the other answers are NO, obtain **CBC, PLATELETS, PT & PTT** only.  
❖ The patient must stop aspirin 2 weeks prior to surgery and Ibuprofen products 2 days prior to surgery.
- 3) If answers in **any item in Part II is YES**, discuss work-up with pediatric hematologist before ordering blood studies.
- 4) If answers to **ANY** of the other questions (except Part I, Question 7) are YES, obtain a **HEMATOLOGY CLEARANCE** & discuss results with hematologist

PATIENT/GUARDIAN'S SIGNATURE: [Signature] DATE: 12/6/17

I have reviewed this medical information with the patient. Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



FOR PATIENT'S PARENTS / LEGAL GUARDIAN: PLEASE NOTE THE DUE DATE.  
WEILL CORNELL MEDICAL COLLEGE – PEDIATRIC OTORHINOLARYNGOLOGY DEPT.  
428 EAST 72<sup>ND</sup> STREET, SUITE 100 NEW YORK, NY 10021  
(646) 962-4780 Fax (212) 746-8124

**PEDIATRIC ANESTHESIA QUESTIONNAIRE**

PATIENT'S NAME: MOOLANI, CAMDEN DATE OF BIRTH: 10/19/2014  
74418700

Child's Current Weight 35 lbs.

**I. BIRTH: CHILD'S BIRTH WEIGHT 7lb 9oz**

- Y ☒ N 1) Was your child born prematurely?  
Y ☒ N 2) Did you have a Caesarian section?  
Y ☒ N 3) Was oxygen used on the child?  
Y ☒ N 4) Was he/she intubated (had a tube in lungs to help him/her breathe)?  
Y ☒ N 5) Was he/she treated in an ICU (Intensive Care Unit or special nursery)?  
Y ☒ N 6) Was he/she on a respirator?

**II. RESPIRATION:**

- Y ☒ N 1) Does your child have asthma, bronchitis or chronic cough?  
Y ☒ N 2) Did your child have a fever in the last seven days (from the date this form is being filled out)?  
Y ☒ N 3) Does your child have a cough or red watery eyes now or in the last 7 days?  
Y ☒ N 4) Has your child been exposed to any communicable diseases in the last 2 weeks? (childhood diseases such as chicken pox?)

**III. CARDIAC:**

- Y ☒ N 1) Was your child a "blue baby"?  
Y ☒ N 2) Does your child have any heart problems?  
Y ☒ N 3) Has any doctor heard a murmur?

**IV. GENERAL:**

- Y ☒ N 1) Does your child have any other medical problems not listed?  
Y ☒ N 2) Does your child have any physical disability or handicaps?  
Y ☒ N 3) Has your child or any relative had a problem with anesthesia?  
Y ☒ N 4) Does your child take any medication? If yes, please list the medications: \_\_\_\_\_  
☒ N 5) Does your child have any allergies? If yes, please list the medications: Amoxicillin (rash)

**V. TRANSFUSION:**

- Y ☒ N 1) Has your child ever had a blood transfusion?  
Y ☒ N 2) Has your child had a blood transfusion in the past 3 months?  
Y ☒ N 3) Was your child jaundiced after birth REQUIRING a blood transfusion?  
Y ☒ N 4) Do you or any relative have a bleeding problem?

**VI. OTHER INFORMATION:**

- Y ☒ N 4) Does your child have a history of night terrors and/or nightmares?

**VII. PREVIOUS SURGERY:**

List operations and approximate dates: Circumcision correction (January 2015)

Please list a phone number where you can be reached during the day if further information is needed (202) 276 - 2191

Signature: [Signature] Relationship to patient: Mother Date: 12/6/17

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