

# NYU HOSPITALS CENTER

## PRE-PROCEDURE MEDICAL OPTIMIZATION FORM

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Label or Addressograph

<b>Section 1: To Be Completed By the Physician Performing the Procedure</b>		<b>Sleep Apnea Screen</b> (High Risk $\geq 3$ Items)	
Procedure-Related Diagnosis: _____		<input type="checkbox"/> <b>S</b> nooring	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Proposed Procedure: _____		<input type="checkbox"/> <b>T</b> ired	Do you often feel tired, fatigued, or sleepy during daytime?
Date of Procedure: _____		<input type="checkbox"/> <b>O</b> bserved	Has anyone observed you stop breathing during your sleep?
PAT Date (if Scheduled): _____		<input type="checkbox"/> <b>P</b> ressure	Do you have or are you being treated for high blood pressure?
<u>Proposed Location:</u>		<input type="checkbox"/> <b>B</b> MI	BMI more than 35 kg/m <sup>2</sup> ?
<input type="checkbox"/> Tisch Campus	<input type="checkbox"/> 38 <sup>th</sup> Street	<input type="checkbox"/> <b>A</b> ge	Age over 50 years old?
<input type="checkbox"/> HJD Campus	<input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>N</b> eck	Neck circumference greater than 40 cm?
		<input type="checkbox"/> <b>G</b> ender	Gender male or post-menopausal female?

<b>Section 2: To Be Completed By Consulting Physician</b>			<b>Past Surgical Hx:</b>
<b>Does the Patient have Any of the Following Conditions?</b>			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Acute Complaints</b> unrelated to the "Procedure-Related Diagnosis" If Yes, describe: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Cardiac Stent:</b> <input type="checkbox"/> Drug Eluting <input type="checkbox"/> Bare Metal <i>If "Yes" to either, see last page of the form regarding management of antiplatelet therapy</i>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>DVT/PE:</b> Date: _____ <input type="checkbox"/> Currently anticoagulated <input type="checkbox"/> IVC Filter	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>HTN:</b> Controlled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>DM:</b> Controlled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Insulin A1c: _____ Date: _____ Microvascular complications: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>ASHD/CAD:</b> <input type="checkbox"/> CABG <input type="checkbox"/> Stent <input type="checkbox"/> Prior MI LVEF: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>CHF:</b> <input type="checkbox"/> Diastolic <input type="checkbox"/> Systolic LVEF: _____ Last Exac Date: _____ Last Diuretic Dose Change: _____ Date: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>OSAS/OHS:</b> <input type="checkbox"/> on PAP Rx at home EPAP: _____ / IPAP: _____ cm H <sub>2</sub> O	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>COPD/Asthma:</b> Controlled? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Systemic Steroid Date: _____ Last Exac: _____ <input type="checkbox"/> Home oxygen – LPM _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Afib:</b> <input type="checkbox"/> Chronic <input type="checkbox"/> Paroxysmal <input type="checkbox"/> Current anticoagulant: _____ Current rhythm: _____ If SR, date last fib: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>CKD:</b> Stable? <input type="checkbox"/> Yes <input type="checkbox"/> No Cr: _____ Date: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>ICD:</b> Indication: _____ Date implanted: _____ Mfr: _____ Last interrogated: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>PPM:</b> Indication: _____ Date implanted: _____ Mfr: _____ Last interrogated: _____	<b>Details and Adnl Past Med Hx:</b>
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>RA/Other Rheum:</b> <input type="checkbox"/> On biologic Rx <input type="checkbox"/> On chronic corticosteroid (Dose: _____)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Hepatitis C+:</b> <input type="checkbox"/> On Treatment <input type="checkbox"/> Completed Treatment <input type="checkbox"/> Never Treated	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>HIV+:</b> Year Dx: _____ CD4: _____ VL: _____ Date: _____ <input type="checkbox"/> HAART	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Cirrhosis:</b> Cause: _____ Alb: _____ AST/ALT: _____ Bili: _____ INR: _____ AlkP: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>GI Bleed:</b> <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Req Transfusion Date: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>EtOH Use:</b> Specify: _____ <input type="checkbox"/> At Risk for Post Op W/D	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Tobacco use:</b> Specify: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Rec Drugs:</b> Specify: _____ <input type="checkbox"/> At Risk for Post Op W/D	
<b>Has the Patient Had Any of the Following Studies/Procedures within the past 2 years?</b>			
<b>IF YES, SUBMIT COPIES OF THE REPORT</b>			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cardiac Catheterization(s)	<input type="checkbox"/> No <input type="checkbox"/> Yes PFT
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Echocardiogram	<input type="checkbox"/> No <input type="checkbox"/> Yes CXR
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stress Test	<input type="checkbox"/> No <input type="checkbox"/> Yes CT Scan
<input type="checkbox"/> No	<input type="checkbox"/> Yes	EKG	<input type="checkbox"/> No <input type="checkbox"/> Yes MRI

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**ALLERGIES:**  NKDA

**Medications:** (Include Herbals, Supplements, Alternative Treatments)

Name	Dose	Freq	Last Taken	Date to Stop	Name	Dose	Freq	Last Taken	Date to Stop

<b>Physical Exam:</b>	BP:	HR:	RR:	T:	SpO2:	Ht:	Wt:
Gen:				GU:			
HEENT:				Lymph:			
NECK:				Msk:			
CV:				Skin:			
Pulm:				Neuro:			
GI:				Psych:			

**Additional Physical Exam Comments:**

**DATA REVIEW:**  Describe pertinent abnormal lab values and other/additional relevant imaging:  
 Lab reports enclosed  
 Labs are pending  
 Please forward copies of PAT Labs to me

Revised Cardiac Risk Index	Risk
<input type="checkbox"/> High Risk Surgery ( <i>e.g. vascular, peritoneal, thoracic</i> )	0 risk factors - 0.4% - 1.0% vs <1% w/ beta-blocker
<input type="checkbox"/> History of Ischemic Heart Disease ( <i>e.g. MI, pos. stress, active angina, need for nitrates, pathologic q on EKG, do not count prior PCI/CABG without other criteria</i> )	1-2 risk factors - 2.2% - 6.6% vs 0.8% - 1.6% w/ beta-blocker
<input type="checkbox"/> History of Heart Failure	3+ risk factors - >9% vs >3% w/ beta-blocker
<input type="checkbox"/> History of cerebrovascular disease	
<input type="checkbox"/> Diabetes mellitus requiring treatment with insulin	
<input type="checkbox"/> Preoperative serum creatinine >2.0 mg/dL (177 µmol/L)	

**Impression:**  
 The patient IS optimized for surgery and **MAY PROCEED** to the operating room as scheduled  
 Without further assessment.  
 Pending review of outstanding labs.  
 Pending review of other study/evaluation (specify): \_\_\_\_\_

Please make **specific** peri-operative recommendations:  
 \_\_\_\_\_  
 \_\_\_\_\_

Check here if you feel that for reasons documented above cardiac risk is so significant surgery should be performed at the Tisch Campus.

**Impression:**  
 The patient IS NOT optimized for surgery.  
 Has had cardiac BMS within last 6 weeks or DES within 12 months.  
 Needs further optimization e.g. control of asthma, blood pressure or diabetes (specify): \_\_\_\_\_

Needs further diagnostic testing (specify): \_\_\_\_\_

Other: \_\_\_\_\_

Form Completed by: \_\_\_\_\_

Printed Name	Title	Telephone	Signature	Date / Time
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# NYU HOSPITALS CENTER

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### NYU Langone Medical Center Clinical Guideline Summary

Management of antiplatelet therapy, patients s/p PCI, undergoing surgery/invasive procedure

For patients status post percutaneous coronary intervention (PCI) who need non-cardiac invasive procedures, optimal outcomes require careful balance of bleeding risk of continuing anti-platelet therapy against risk of thrombosis and acute myocardial infarction. BEFORE procedure is scheduled, agreement and clarity about anti-platelet therapy management must be achieved through a discussion between the procedure physician (who best understands the bleeding risk) and the cardiologist (who best understands the risk of thrombosis and acute myocardial infarction). **JOINT DECISION-MAKING MUST BE DOCUMENTED IN THE MEDICAL RECORD. FAILURE TO DOCUMENT ANTI-PLATELET THERAPY DECISION-MAKING WILL RESULT IN PROCEDURE CANCELLATION.**

For major procedures, all patients must be followed while in hospital by an NYULMC cardiologist. If the patient's usual cardiologist is not affiliated with NYULMC, preoperative consultation must be obtained prior to scheduled procedure with an NYULMC cardiologist who will follow the patient during admission.

In addition, patients scheduled to undergo an inpatient procedure at HJD will be evaluated preoperatively by a hospital-based intensivist or NYU cardiologist, for consideration of performing the procedure at Tisch Hospital.

This form may be used to document decision-making. Please fax to PST,                     .

Patient name: \_\_\_\_\_ MRN: \_\_\_\_\_

Procedure: \_\_\_\_\_ Date scheduled: \_\_\_\_\_

Procedure physician: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

	<i>Usual dose</i>	<i>NYULMC guideline recommendation</i>	<i>Recommendation of procedure physician and cardiologist</i>
Aspirin	_____ mg daily  <input type="checkbox"/> No aspirin	Continue, unless very high bleeding risk. If aspirin must be stopped, stop 3 days prior to procedure.	<input type="checkbox"/> Continue aspirin throughout the perioperative period at a dose of _____ mg daily  <input type="checkbox"/> Stop aspirin on ___ / ___ / ___ (mm/dd/yy).
<input type="checkbox"/> Clopidogrel (Plavix®) <input type="checkbox"/> Prasugrel (Efient®) <input type="checkbox"/> Ticagrelor (Brilinte®)  (thienopyridines)	_____ mg daily  _____ mg twice daily  <input type="checkbox"/> No thienopyridine	Continue, unless high bleeding risk. If thienopyridine must be stopped, stop 3 – 5 days prior to procedure.	<input type="checkbox"/> Continue thienopyridine throughout the perioperative period at a dose of _____ mg daily or _____ mg twice daily  <input type="checkbox"/> Stop thienopyridine on ___ / ___ / ___ (mm/dd/yy).