Ranawat Orthopedics HSS

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- ❒ Anil S. Ranawat, M.D.

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician(s) and as a member(s) of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopedics HSS:

Dr. Amar Ranawat:
Dr. Amar Ranawat is a consultant for Ceramtec, LTD, Convatec and DePuy Orthopedics, Inc. Dr. Ranawat also receives research support from Ceramtec, LTD.

Dr. Anil Ranawat:
Dr. Anil Ranawat is a consultant on the unicompartmental knee team for Stryker - MAKO Surgical Corp. Dr. Ranawat is Editor-in-Chief for which receives salary support from Springer, and receives royalties from Elsevier, Inc.

Dr. Chitranjan Ranawat:
Dr. Chitranjan Ranawat is a consultant and product designer for DePuy Orthopedics, Inc. on the Sigma® and Attune™ total knee prosthesis systems for which he receives royalty payments.

WE DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with us, you may either contact the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship disclosed to you, you choose to refuse a particular treatment, operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

Signature_____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

For Office Use Only: If the patient does not sign this acknowledgment form, record here the good faith efforts made to obtain this acknowledgement.

_____
_____
_____

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

SEX ASSIGNED AT BIRTH	SEX LISTED WITH HEALTH INSURANCE	WHAT IS YOUR GENDER IDENTITY?	PREFERRED PRONOUNS
❑ FEMALE ❑ MALE ❑ INTERSEX	❑ FEMALE ❑ MALE	❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____	❑She/Her ❑ Ze/Hir ❑He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY?	RACE	ADDITIONAL RACE	ETHNICITY
❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE			

FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH
		❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO

MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., stret, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

FULL NAME CONTACT #2	ADDRESS

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ❑ YES ❑ NO	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

New Patient Questionnaire – HIP

Adult Reconstruction & Joint Replacement

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

Chief Complaint

Laterality	○ Left	○ Right	○ Both

Please describe your symptoms: (Mark all that apply)

☐	Throbbing pain	☐	Radiating pain	☐	Dull pain	☐	Sharp pain
☐	Catching/Locking	☐	Swelling	☐	Stiffness	☐	Instability
	Other:						

Where is the pain located in your hip? (Mark all that apply)

☐	Groin	☐	Thigh	☐	Outside	☐	Buttocks	Other:	

Current Pain Level (no pain 0 – 10 highest)

While Walking

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

While negotiating stairs

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

At rest (sitting, lying down, sleeping)

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

When did this condition start? _____

How did it start? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you EVER tried any prior conservative treatment?	Yes	No	How long?	Did it help?
Acupuncture or holistic remedies	○	○		.
Arthroscopic surgery	○	○		.
Brace / Cane / Crutches / Walker	○	○		.
Cortisone injections	○	○		.
Dietary supplements	○	○		.
Viscosupplementation (Gel injections)	○	○		.
NSAIDS *(eg: Ibuprofen, Aspirin, Naproxen, Celebrex, Voltaren)*	○	○		.
Narcotics	○	○		.
Physical therapy	○	○		.
Weight loss	○	○		.
Exercise program	○	○		.
Activity modification / Lifestyle change	○	○		.

Functional Assessment

Do you have a limp?

○ No	○ Slight	○ Moderate	○ Severe

What type of support do you use for walking?

○ None	○ Cane (long walks)	○ Cane (full time)	○ Crutch(es)	○ Walker

What distance are you able to walk?

○ Unlimited	○ 6 blocks	○ 2-3 blocks	○ < 1 block	○ Bed to chair

How do you climb stairs?

○ Normally	○ With banister	○ With assistance of a person	○ Unable

To what extent are you able to put on shoes and socks?

○ Easy	○ Difficult	○ Unable

Describe the extent to which you are able to sit:

○ Any chair, 1 hour	○ High chair, 30 minutes	○ Unable

Are you able to use public transportation?

○ Yes	○ No

Do you find this situation to be:

○ Acceptable	○ Unacceptable

HOOS, JR. Hip Survey

Instructions: This survey asks for you view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Which Hip:

○ Left	○ Right	○ Both

Pain: What amount of hip pain have you experienced the last week during the following activities?

1. Going up or down stairs:

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

2. Walking on an uneven surface:

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experience in the last week due to your hip.

3. Rising from sitting:

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

4. Bending to floor/pick up an object:

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

5. Lying in bed (turning over, maintaining hip position):

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

6. Sitting:

○ None	○ Mild	○ Moderate	○ Severe	○ Extreme

Medications: *Please list the medications that you CURRENTLY take*

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Allergies: *Please include any known allergies*

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Are you allergic to iodine? ○ Yes ○ No

Are you allergic to latex? ○ Yes ○ No

Are you allergic to metal, jewelry, or nickel? ○ Yes ○ No

Medical History

Please select any past or current medical conditions below:			
Anxiety	Depression	Kidney disorder	Pulmonary embolus
Arrhythmia (Irregular heartbeat)	Diabetes	Low acting thyroid	Reflux
Asthma	Heart attack	Open wounds/Ulcers	Rheumatoid arthritis
Bleeding problems	Heart failure (CHF)	Osteoarthritis	Seizures
Blood clots (DVT-PE)	High blood pressure	Osteoporosis	Stomach ulcers
Cancer	High cholesterol	Peripheral vascular disease	Stroke
Coronary artery disease	Infection	Pneumonia	Other:

Surgical and Hospitalization History

Previous operation/Hospitalization	Occurrence date (approx.)
1.	
2.	
3.	
4.	
5.	

Have you ever had a problem with anesthesia? ○ Yes ○ No ○ Problem: _____

Have you ever had complications from prior surgery? ○ Yes ○ No ○ Problem: _____

Family History

What medical problems run in your direct family?

Family member	Problem	Alive/Deceased
Father		
Mother		
Brother		
Sister		
Grandfather		
Grandmother		

Social History

Are you a tobacco user? ○ Yes ○ No

If yes, what? _____ How much? _____

Do you consume alcohol? ○ Yes ○ No

If yes, what kind? _____ Drinks per week? _____

Recreational drug use? ○ Yes ○ No

If yes, what drug? _____ How much and how often? _____

List any recreational activities / sports that you enjoy: _____

What do you do for a living? _____

With whom do you live? _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? ○ Yes ○ No

Have you ever had a MRSA Infection? ○ Yes ○ No

Do you have any of the following medical devices? (Mark all that apply)

☐ Pain Pump	☐ Neurostimulator	☐ Pacemaker and/or Defibrillator	☐ Shunt for hydrocephalus

Do you have diabetes? ○ Yes ○ No

If yes, do you have an insulin pump? ○ Yes ○ No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? ○ Yes ○ No

Immunizations and Falls Screening

Have you received the pneumonia vaccine? ○ Yes ○ No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? ○ Yes ○ No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? ○ Yes ○ No

If yes, do you have vision problems that may have contributed to your fall? ○ Yes ○ No

Review of Systems

Are you currently having, or have you had any of these problems in the past year? (Select all that apply):

Constitutional	Hematologic	Respiratory	Skin
☐ Chills	☐ Easy bruising/bleeding	☐ Increased sputum	☐ Sores/ulcers
☐ Fever	☐ Blood clots in legs	☐ Cough	☐ Itching
☐ Sleep difficulty	☐ Blood clots in lungs	☐ Difficulty breathing	☐ Dryness
☐ Fatigue		☐ Wheezing	☐ Hives
☐ Night sweats		☐ Excessive snoring	☐ Rash
☐ Weight Change			☐ Mole changes
☐ None	☐ None	☐ None	☐ None

ENT	Cardiovascular	Endocrine	Musculoskeletal
☐ Double vision	☐ Chest pain	☐ Cold intolerance	☐ Joint pain
☐ Headaches	☐ Leg swelling	☐ Heat intolerance	☐ Arthritis
☐ Hearing loss	☐ Palpitations	☐ Excessive thirst	☐ Muscle pain
☐ Cataracts	☐ Poor circulation	☐ Excessive hunger	☐ Joint swelling
☐ Glaucoma	☐ Cold hands		☐ Muscle cramps
☐ Dry eyes	☐ Cold feet		☐ Muscle weakness
☐ Sinus problem			☐ Joint stiffness
☐ None	☐ None	☐ None	☐ None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
☐ Abdominal pain	☐ Bladder incontinence	☐ Seizures	☐ Depression
☐ Trouble swallowing	☐ Blood in urine	☐ Dizziness	☐ Anxiety
☐ Heartburn	☐ Urinary difficulty	☐ Weakness	☐ Mood swings
☐ Nausea	☐ Painful urination	☐ Loss of balance	☐ Memory problems
☐ Vomiting	☐ Urinary retention	☐ Numbness	☐ Nervousness
☐ Constipation	☐ Urinary urgency	☐ Paralysis	☐ Insomnia
☐ None	☐ None	☐ None	☐ None

Eyes	Environmental Allergies	Mouth
☐ Dryness	☐ Pollen	☐ Bad breath
☐ Discharge	☐ Dust Mites	☐ Bleeding gums
☐ Double Vision	☐ Pets/Animals	☐ Sores – ulcers
☐ Pain	☐ Mold/Mildew	☐ Dental problem
☐ Redness	☐ Metal	☐ Loss of taste
☐ None	☐ None	☐ None

VR-12 Health Survey

Instructions: This questionnaire asks for your views about your health. Answer every question by marking the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

○ Excellent	○ Very Good	○ Good	○ Fair	○ Poor

2. Does your health now limit:

   a. Moderate activities such as moving a table, pushing a vacuum, bowling or playing golf?

○ Yes, limited a lot	○ Yes, limited a little	○ No, not limited at all

   b. Climbing several flights of stairs?

○ Yes, limited a lot	○ Yes, limited a little	○ No, not limited at all

3. During the past 4 weeks, has your physical health resulted in:

   a. Accomplishing less than you would like?

○ None of the time	○ A little of the time	○ Some of the time	○ Most of the time	○ All of the time

   b. Being limited in the **kind** of work or other activities you have attempted?

○ None of the time	○ A little of the time	○ Some of the time	○ Most of the time	○ All of the time

4. During the past 4 weeks, **as a result of any emotional problems** (such as feeling depressed or anxious):

   a. Have you **accomplished less** than you would like?

○ None of the time	○ A little of the time	○ Some of the time	○ Most of the time	○ All of the time

   b. Have you not completed work or other activities as **carefully** as usual?

○ None of the time	○ A little of the time	○ Some of the time	○ Most of the time	○ All of the time

5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and house work)?

○ Not at all	○ A little bit	○ Moderately	○ Quite a bit	○ Extremely

6. During the past 4 weeks, have you felt calm and peaceful?

○ All of the time	○ Most of the time	○ Good bit of the time	○ Some of the time	○ Little of the time	○ None of the time

7. During the past 4 weeks, did you have a lot of energy?

○ All of the time	○ Most of the time	○ Good bit of the time	○ Some of the time	○ Little of the time	○ None of the time

8. During the past 4 weeks, have you felt downhearted and blue?

○ All of the time	○ Most of the time	○ Good bit of the time	○ Some of the time	○ Little of the time	○ None of the time

9. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (such as visiting friends, relatives, etc…)?

○ None of the time	○ A little of the time	○ Some of the time	○ Most of the time	○ All of the time

10. Compared to 1 year ago, how would you rate your **physical health** in general now?

○ Much better	○ Slightly better	○ About the same	○ Slightly worse	○ Much worse

11. Compared to 1 year ago, how would you rate your **emotional problems now** (such as feeling anxious, depressed or irritable)?

○ Much better	○ Slightly better	○ About the same	○ Slightly worse	○ Much worse

ACTIVITY SURVEY (LEAS)

*Please read through each description given below, pick only **ONE** description that best describes your regular daily activities and put a check in that box.*

CHECK ONLY ONE (1) BOX ON THIS PAGE

☐ a. I am confined to bed all day.

☐ b. I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc)

☐ c. I am either in bed or sitting in a chair most of the day.

☐ d. I sit most of the day, except for minimal transfer activities, no walking or standing.

☐ e. I sit most of the day, but I stand occasionally and walk a minimal amount in my house.

(I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation.)

☐ f. I walk around my house to a moderate degree but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment.

☐ g. I walk around my house and go outside at will, walking one or two blocks at a time.

☐ h. I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting).

☐ i. I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (weather permitting).

j. I am up and about at will in my house and outside. I also work outside the house in a:

- ☐ minimally
- ☐ moderately
- ☐ extremely active job

k. I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming:

- ☐ occasionally (2-3 times per month)
- ☐ 2-3 times per week
- ☐ daily

l. I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports

- ☐ occasionally (2-3 times per month)
- ☐ 2-3 times per week
- ☐ daily