

Ranawat Orthopedics HSS

- ☐ Chitranjan S. Ranawat, M.D.
- ☐ Amar S. Ranawat, M.D.
- ☐ 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.

**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 ☐ FEMALE ☐ MALE ☐ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ☐ FEMALE ☐ MALE	WHAT IS YOUR GENDER IDENTITY? ☐ SAME AS SEX LISTED WITH INSURANCE ☐ OTHER: _____		PREFERRED PRONOUNS ☐ 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? ☐ YES ☐ NO ☐ UNKNOWN ☐ DECLINE		RACE	ADDITIONAL RACE	ETHNICITY
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., street, 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

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 – KNEE

Adult Reconstruction & Joint Replacement

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

Chief Complaint

Laterality	Left	Right	Both
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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 knee? (Mark all that apply)

Front	Back	Inside	Outside	Other:
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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

What distance are you able to walk?

Unlimited	10-20 blocks	5-10 blocks	< 5 block	House bound	Unable
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How do you climb **UP** stairs?

Normally	With handrail for balance	With handrail to pull myself up	Unable
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How do you climb **DOWN** stairs?

Normally	With handrail for balance	With handrail to support myself	Unable
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What type of support do you use for walking?

None	Cane(s)	Crutch(es)	Walker
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How do you get out of a chair?

Normally	Arm rest for balance	Arm rest to push myself	Unable
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Are you able to use public transportation?

Yes	No
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Do you find this situation to be:

Acceptable	Unacceptable
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KOOS, JR. Knee Survey

Instructions: This survey asks for you view about your knee. This information will help us keep track of how you feel about your knee 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 Knee:

Left	Right	Both
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Stiffness: Amount of joint stiffness you have experienced the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
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Pain: What amount of knee pain have you experienced the last week during the following activities?

2. Twisting/pivoting on your knee:

None	Mild	Moderate	Severe	Extreme
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3. Straightening knee fully:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

4. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

5. Standing upright:

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 knee.

6. Rising from sitting:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

7. Bending to floor/pick up an object:

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
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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 Yes No

March 31st? 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
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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
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- b. Climbing several flights of stairs?

Yes, limited a lot	Yes, limited a little	No, not limited at all
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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
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- 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
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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
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- 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
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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
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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
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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
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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
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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
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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
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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
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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 <u>ONE</u> (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