NYU HOSPITALS CENTER

PRE-PROCEDURE
MEDICAL OPTIMIZATION FORM

Lastname	Firstname	
MRN	Sex	DOB
ACCT	Pt Type	

Section 1: To Be Completed By the Physician Performing the Procedure

Procedure-Related Diagnosis: ____________________

Proposed Procedure: ____________________

Date of Procedure: ____________________

PAT Date (if Scheduled): ____________________

Proposed Location:

☐ Tisch Campus ☐ 38th Street
☐ HJD Campus ☐ Other:__________

Sleep Apnea Screen (High Risk >=3 Items)

☐	**S**noring	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
☐	**T**ired	Do you often feel tired, fatigued, or sleepy during daytime?
☐	**O**bserved	Has anyone observed you stop breathing during your sleep?
☐	**P**ressure	Do you have or are you being treated for high blood pressure?
☐	**B**MI	BMI more than 35 kg/m^2?
☐	**A**ge	Age over 50 years old?
☐	**N**eck	Neck circumference greater than 40 cm?
☐	**G**ender	Gender male or post-menopausal female?

Section 2: To Be Completed By Consulting Physician

Does the Patient have Any of the Following Conditions?

☐ No	☐ Yes	**Acute Complaints** unrelated to the "Procedure-Related Diagnosis" If Yes, describe:__________	
☐ No	☐ Yes	**Cardiac Stent:**	☐ Drug Eluting ☐ Bare Metal *If "Yes" to either, see last page of the form regarding management of antiplatelet therapy*
☐ No	☐ Yes	**DVT/PE:**	Date:____ ☐ Currently anticoagulated ☐ IVC Filter
☐ No	☐ Yes	**HTN:**	Controlled? ☐ Yes ☐ No
☐ No	☐ Yes	**DM:**	Controlled? ☐ Yes ☐ No ☐ Insulin A1c:___ Date:____ Microvascular complications: __________
☐ No	☐ Yes	**ASHD/CAD:**	☐ CABG ☐ Stent ☐ Prior MI LVEF:______
☐ No	☐ Yes	**CHF:**	☐ Diastolic ☐ Systolic LVEF:___ Last Exac Date: ______ Last Diuretic Dose Change: __________ Date:______
☐ No	☐ Yes	**OSAS/OHS:**	☐ on PAP Rx at home EPAP:____/ IPAP: _____cm H_2O
☐ No	☐ Yes	**COPD/Asthma:**	Controlled? ☐ Yes ☐ No Last Systemic Steroid Date: ________ Last Exac: ________ ☐ Home oxygen – LPM _____
☐ No	☐ Yes	**Afib:**	☐ Chronic ☐ Paroxysmal ☐ Current anticoagulant: __________ Current rhythm: _______ If SR, date last fib: __________
☐ No	☐ Yes	**CKD:**	Stable? ☐ Yes ☐ No Cr: _____ Date:________
☐ No	☐ Yes	**ICD:**	Indication:__________ Date implanted : __________ Mfr:________ Last interrogated:______
☐ No	☐ Yes	**PPM:**	Indication:__________ Date implanted : __________ Mfr:________ Last interrogated:________
☐ No	☐ Yes	**RA/Other Rheum:**	☐ On biologic Rx ☐ On chronic corticosteroid (Dose:________)
☐ No	☐ Yes	**Hepatitis C+:**	☐ On Treatment ☐ Completed Treatment ☐ Never Treated
☐ No	☐ Yes	**HIV+**	Year Dx: ______ CD4: _____ VL: _____ Date: _____ ☐ HAART
☐ No	☐ Yes	**Cirrhosis:**	Cause:__________ Alb: ____ AST/ALT:____ Bili:____ INR:____ AlkP:____
☐ No	☐ Yes	**GI Bleed:**	☐ Upper ☐ Lower ☐ Req Transfusion Date:__________
☐ No	☐ Yes	**EtOH Use:**	Specify:__________ ☐ At Risk for Post Op W/D
☐ No	☐ Yes	**Tobacco use:**	Specify:__________
☐ No	☐ Yes	**Rec Drugs:**	Specify:__________ ☐ At Risk for Post Op W/D

Has the Patient Had Any of the Following Studies/Procedures within the past 2 years?
IF YES, SUBMIT COPIES OF THE REPORT

☐ No	☐ Yes	Cardiac Catheterization(s)	☐ No	☐ Yes	PFT
☐ No	☐ Yes	Echocardiogram	☐ No	☐ Yes	CXR
☐ No	☐ Yes	Stress Test	☐ No	☐ Yes	CT Scan
☐ No	☐ Yes	EKG	☐ No	☐ Yes	MRI

Past Surgical Hx:

Details and Addnl Past Med Hx:

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MEDICAL OPTIMIZATION FORM

Label or Addressograph

ALLERGIES: ☐ NKDA

Medications: (Include Herbals, Supplements, Alternative Treatments)

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

Physical Exam: 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:

☐ Lab reports enclosed

☐ Labs are pending

☐ Please forward copies of PAT Labs to me

☐ Describe pertinent abnormal lab values and other/additional relevant imaging:

Revised Cardiac Risk Index

☐	High Risk Surgery *(e.g. vascular, peritoneal, thoracic)*	0 risk factors - 0.4% - 1% vs <1% w/ beta-blocker
☐	History of Ischemic Heart Disease *(e.g. MI, pos. stress, active angina, need for nitrates, pathologic q on EKG, do not count prior PCI/CABG without other criteria)*	1-2 risk factors - 2.2% - 6.6% vs 0.8% - 1.6% w/ beta-blocker
☐	History of Heart Failure	
☐	History of cerebrovascular disease	3+ risk factors - >9% vs >3% w/ beta-blocker
☐	Diabetes mellitus requiring treatment with insulin	
☐	Preoperative serum creatinine >2 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:

				AM/PM
Printed Name	Title	Telephone	Signature	Date / Time

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: ______________________

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