

TLC Surgical Center

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

Summary of Past & Current Visits:

[illegible]

CHART CHECKLIST- TIVA, GENERAL, MAC

Pg #	Initials	Left Side	Pg #	Initials	Right Side
1	JA	Patient Information (Demographics)	Pre - Operative Forms		
2	JA	2 copies - Driver License and if applicable ID Card Copy	1	JA	Chart Checklist (this document)
3	JA	Acknowledgement of Legal Relationship	2	JA	Surgery Consent
4	JA	Advanced Directive	3	JA	Anesthesia Consent
5	JA	Patient Rights	4	JA	Pre-Anesthetic Evaluation/ Post Anesthetic Evaluation
6	JA	Patient Responsibilities	5	JA	History and Physical/ Medical Clearance
7	JA	Privacy Acknowledgement Form	6	JA	Patient Health Questionnaire
8	JA	Arbitration Agreement	7	JA	MH/VTE risk assessment
9		Insurance Documents, Pre-Cert (if applicable)	8	JA	Medication Reconciliation
10		Laboratory Requisition (if pathology sent)	9	JA	Pre-Op/ Post-Op Physician Orders
			10	JA	Pre-Op contact/ Notes
			11	JA	Nursing Assessment
Chart Review			Labs / X - ray		
		No Blanks on the forms - ANY form!	1	N/A	Pathology Report (if applicable)
		Presence/Absence of Allergies noted	2	JA	Lab Tests/Lab Work (Blood, urine, MRI, X-ray, EKG, off-site pregnancy test, etc.)
		Consent Complete, no blanks, all signees	Intra - Operative Forms		
		Pre-Op labs initialed by RN if normal, by MD if results outside normal range	1	JA	Intra-Operative Nursing Record
		Anesthesia evaluation and anesthesia record, complete, signed	2	JA	Surgical Safety Checklist
		Discharge evaluation signed by MD immediately prior to discharge - TIMED	3	JA	Treatment Record
		Orders signed by MD, noted, timed by RN	4	JA	Anesthesia Record
		Pathology reports signed by MD	Post - Operative Forms		
			1	JA	Dictated Operative Report
			2	JA	Physician's Handwritten Op Note
			3	JA	Post Anesthesia Care Orders
			4	JA	Recovery Room Record
			5	JA	Nursing Notes
			6	JA	Discharge Instructions Signed, Timed
			7	N/A	Copy of Prescription (If available/applicable)
			8	JA	Post-Op Contact/Phone Call

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TLC SURGICAL CENTER

AUTHORIZATION AND CONSENT TO SURGERY AND/OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES AND OR THE RENDERING OF OTHER MEDICAL SERVICES

TO: Christine Keenan (PATIENT). YOUR SURGEON IS DR. Jaime Schwartz

THE SURGERY CENTER MAINTAINS PERSONNEL AND FACILITIES TO ASSIST YOUR PHYSICIANS AND SURGEONS IN THEIR PERFORMANCE OF VARIOUS SURGICAL OPERATIONS AND OTHER SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES. THESE OPERATIONS AND PROCEDURES MAY INVOLVE RISKS OF UNSUCCESSFUL RESULTS, COMPLICATIONS, INJURY, OR EVEN DEATH, FROM BOTH UNKNOWN AND UNFORSEEN CAUSES, AND NO WARRANTY OR GUARANTEE IS MADE AS TO RESULT OR CURE.

YOU HAVE THE RIGHT TO BE INFORMED OF SUCH RISKS AS WELL AS THE NATURE OF THE OPERATION OR PROCEDURE. THE EXPECTED BENEFITS OR EFFECTS OF SUCH OPERATION OR PROCEDURE, AND THE AVAILABLE ALTERNATIVE METHODS OF TREATMENT AND THEIR RISKS AND BENEFITS. YOU HAVE THE RIGHT TO BE INFORMED WHETHER YOUR PHYSICIAN HAS ANY INDEPENDENT MEDICAL RESEARCH OR ECONOMIC INTEREST RELATED TO THE PERFORMANCE OF THE PROPOSED OPERATION OR PROCEDURE. EXCEPT IN CASES OF EMERGENCY, OPERATIONS OR PROCEDURES ARE NOT PERFORMED UNTIL YOU HAVE HAD THE OPPORTUNITY TO RECEIVE THIS INFORMATION AND HAVE GIVEN YOUR CONSENT. YOU HAVE THE RIGHT TO CONSENT TO OR TO REFUSE ANY PROPOSED OPERATION OR PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE.

YOUR PHYSICIAN(S) AND OR SURGEON(S) HAVE RECOMMENDED THE FOLLOWING OPERATION(S) OR PROCEDURE(S):

Lipedema Reduction surgery to posterior legs, thighs and right hip
Dermatoma Reduction surgery of abdomen with possible direct excision, liposuction and
skin excision

UPON YOUR AUTHORIZATION AND CONSENT, THIS OPERATION OR PROCEDURE, TOGETHER WITH ANY DIFFERENT OR FURTHER PROCEDURES WHICH IN THE OPINION OF THE SUPERVISING PHYSICIAN OR SURGEON MAY BE INDICATED DUE TO AN EMERGENCY, WILL BE PERFORMED ON YOU. THE OPERATIONS OR PROCEDURES WILL BE PERFORMED BY THE SUPERVISING PHYSICIAN OR SURGEON NAMED ABOVE, OR IN THE EVENT THAT THE PHYSICIAN IS UNABLE TO PERFORM OR COMPLETE THE PROCEDURE, A SURGEON NAMED ABOVE OR TOGETHER WITH ASSOCIATES AND ASSISTANTS, INCLUDING ANESTHESIOLOGISTS, PATHOLOGISTS, OR RADIOLOGISTS AFFILIATED WITH THE TLC SURGICAL CENTER, LLC. TO WHOM THE SUPERVISING PHYSICIAN OR SURGEON MAY ASSIGN DESIGNATED RESPONSIBILITIES. THE PERSON IN ATTENDANCE FOR THE PURPOSE OF PERFORMING SPECIALIZED MEDICAL SERVICES, SUCH AS ANESTHESIA, RADIOLOGY, OR PATHOLOGY ARE NOT AGENTS OR EMPLOYEES.

IF YOUR PHYSICIAN DETERMINES THAT THERE IS A REASONABLE POSSIBILITY THAT YOU MAY NEED A BLOOD TRANSFUSION AS A RESULT OF THE SURGERY OR PROCEDURE TO WHICH YOU ARE CONSENTING. THE TRANSFUSION WILL BE PERFORMED AT A NEARBY ACCREDITED HOSPITAL. OUR PHYSICIAN WILL INFORM YOU OF THIS AND WILL PROVIDE YOU WITH A BROCHURE REGARDING BLOOD TRANSFUSIONS. BY YOUR SIGNATURE BELOW, YOU AUTHORIZE THE PATHOLOGIST TO USE HIS OR HER DISCRETION IN DISPOSITION OR USE OF ANY MEMBER, ORGAN, OR OTHER TISSUE REMOVED FROM YOUR PERSON DURING THE OPERATION OR PROCEDURE SET FORTH ABOVE. I AUTHORIZE THE REVIEW OF MY MEDICAL RECORDS BY NON-STAFF PHYSICIAN (PEER REVIEW) IN THE INTEREST OF IMPROVING CARE.

YOUR SIGNATURE ON THIS FORM INDICATES THAT (1) YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED IN THIS FORM, (2) THE OPERATION OR PROCEDURE SET FORTH ABOVE HAS BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN, (3) YOU HAVE HAD A CHANCE TO ASK QUESTIONS, (4) YOU HAVE RECEIVED ALL OF THE ABOVE INFORMATION YOU DESIRE, CONCERNING THE OPERATION OR PROCEDURE, AND (5) YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THEIR OPERATION OR PROCEDURE.

SIGNATURE: [Signature] DATE: 9/14/22 TIME: 0600

IF SIGNED BY OTHER THAN PATIENT INDICATE RELATIONSHIP: _____

WITNESS: [Signature] DATE: 9/14/22 TIME: 0600

PHYSICIAN: [Signature] DATE: 9/14/22 TIME: _____

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PATIENT CONSENT FOR ANESTHESIA

I understand that the operating surgeon will be occupied solely with the surgery and that the administration of anesthesia is an independent function. I consent for administration of anesthesia and/or drugs as may be necessary to be administered by an Anesthesiologist or a CRNA. Local anesthesia to be administered by Surgeon as appropriate.

Please initial below to acknowledge your understanding of the following:

- ☒ I will need anesthesia services for the surgical procedure(s) to be done, and that the type of anesthesia to be used will depend on the procedure and my physical condition.
- ☒ Anesthesia is a specialty medical service, which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of medical, surgical, or obstetrical procedure.
- ☒ During the course of the surgical procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and wellbeing.
- ☒ My anesthetic services may be provided by anesthesiologists or by certified nurse anesthetists (CRNA's)
- ☒ No guarantees have been made by anyone regarding the anesthesia services, which I am agreeing to have.

Type of Anesthesia and Definitions

☒ General Anesthesia / TIVA

1. Endotracheal anesthesia- anesthesia and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth.
2. Mask anesthesia- gases are passed through a mask, which covers the nose and mouth.
3. Total Intravenous Anesthesia- technique of general anesthesia using combination of agents given by intravenous route

☐ Regional Anesthesia

1. Epidural anesthesia- A small catheter is inserted into epidural (spinal) space so that anesthetizing agents may be given to prolong the duration of anesthesia.
2. Spinal Anesthesia- The anesthetic agent is injected into the spinal subarachnoid space to produce loss of sensation.
3. Nerve Blocks- Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.

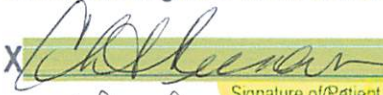
☐ Monitored Anesthesia Care (MAC): Includes the monitored of at least blood pressure, oxygenation, pulse and mental state, supplementing sedation and analgesia as needed.

☐ Local Anesthesia

1. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body for example, the surgical site.
2. Topical Anesthesia- Surface anesthesia is produced by direct application of anesthetizing agents on skin or mucous membranes.

RISKS AND COMPLICATIONS: I understand that all anesthetics involve risks and complications from both known and unknown causes. Including but not limited to: allergic/adverse reaction, aspiration, backache, brain damage, coma, sore throat, lip injury, dental damage, stroke, heart attack, muscle ache, headaches, nausea, ophthalmic (eye) injury, pain, paralysis, inability to reverse the effects of anesthesia, infection, localization swelling or redness, seizures, wrong site for injection of anesthesia, pneumonia, nerve damage, bleeding, infection, intra-operative awareness and death.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent. I agree to the administration of the anesthesia prescribed for me. I recognize the alternative to acceptance of anesthesia might be no anesthesia for the procedure.

x  9/13/22
Signature of Patient Date Time
J. Cordillo 9/14/22 0600
Witness Date Time

 9/14/22
Anesthesia provider signature Date Time

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240 S. La Cienega, Suite 210
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Christine Keenan

DOS 09.14.22

DOB 02.21.65

817.773.0435

SURGICAL CENTER *insurance*

PRE-ANESTHESIA EVALUATION AND PAST MEDICAL HISTORY

PROPOSED PROCEDURE: post. legs/thighs LRS
LRS/dercums abdomen

Cardiac:

HTN, HLPD
PVD

Renal:

CKD

GERD:

GERD UC, const
IBS chrons

Respiratory:

asthma

Hepatic:

* Dercums

Other:

Fibromyalgia

Gout

Osteoporosis

Social History:

STOP-bang score:

Dental cyst

Neuro:

depression, anxiety

Endocrine:

DM2, hypothyroid

Diagnostics:

EKG: JB 8/10

CXR: WNL

8/10 Labs: 5.3 15.1 273 10.9 31.0
45.5 140 100 53 121
4.6 19 1.79 5/16 21/24

Current Medications:

Mometrix, Welbutrin, Meperbol, Trazadone, Gabapentin, Oxycodone, tramadol, HCTZ, weekly ketamine infusions, amitriptyline, VitD

ALLERGIES:

Morphine adhesive
bee stings

Past Surgical/Anesthesia History:

Panniculectomy LRS (03/22), thyroidectomy prenat, back sx, lap chole
Dental cyst, colonoscopy, gastric bypass, carpal tunnel, hysterectomy

PHYSICAL EXAM

Female: 57

Male: _____

Height: 65 in

Weight: 248 lbs

IBW: _____

ASA STATUS:

I ☐II ☐III ☒

NPO:

9/13/22 @ 2130

HR: 90

BP: 149/85

SpO2: 95%

Temp: 97.3

RR: 16

AIRWAY

Mallampati: MP I

ROM: F2ROM

TMD: 73 Fb

Teeth: intact

PHYSICAL ASSESSMENT

Cardiac auscultation:

Pulmonary auscultation:

Other:

Anesthesia Plan:

GA

MAC

Notes:

ANESTHESIA PROVIDER:

Jaime Chen

DATE/TIME:

9.14.22

POST-ANESTHESIA EVALUATION

Pt Condition:

☒ Awake☒ Stable☐ Drowsy☐ UnarousableAirway: ☐ Nasal Cannula L/min _____☒ Facemask L/min _____Vital signs stable: Yes ☒ No ☐Anesthesia Complications: Yes ☐ No ☒

NOTES:

ANESTHESIA PROVIDER:

Jaime Chen L. Johnson

DATE/TIME:

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History & Physical

Proposed Procedure/Chief Complaint/Current Illness: Lipedema / Dercums; lipedema reduction

surgery to posterior legs, thighs + right hip, Dercums reduction surgery of abdomen
Pre Operative Diagnosis: with possible direct excision, liposuction and skin excision

Lipedema/Dercums

Past Medical History/Review of Systems: ☐ Healthy

Depression/Anxiety
Previous Illness & Family History:

Current Medications w/Dosages: ☐ None, or ☒ Medication Reconciliation form reviewed

Allergies/Abnormal reactions: ☐ None, or: Morphine, Bee stings: reaction is
anaphylactic

Past Surgical History:

☐ Past Anesthesia, No Complications

Panniculectomy (2020), Pineal cyst/lipoma removal (2019), Gastric bypass (2015), Carpal tunnel (2014),
Hysterectomy (2010), Thyroid removal (2004), t5-s1 (1986), Cholecystectomy (1985)

Bleeding tendencies:

PHYSICAL EXAMINATION

BP: 149/85 HR: 80 Temp: 97.3 Resp: 19 SpO₂: 98% Ht: 5'5" Wt: 245 Pain level: 2 /10

Skin: ☒ WNL

Head & Neck: ☒ WNL

Heart: ☒ WNL

Neurological: ☒ WNL

Lungs: ☒ WNL

Abdomen: ☒ WNL

Extremities: ☒ WNL

Assessment and Plan

☒ No Changes to Health Assessment completed by PCP

ASA Status: ☐ I ☐ II ☒ III

Plan: ☐ Local Anesthesia ☒ General Anesthesia ☐ MAC ☐ IV Sedation

☒ Procedures, risks, benefits and alternatives discussed with patient including the risk of not proceeding with the procedure. Patient agrees to proceed.

Signed: [Signature], M.D. Date: 9/14/22 Time:

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Patient Health Questionnaire

INSTRUCTIONS TO THE PATIENT - The intention of this questionnaire is to help your anesthetist select the proper anesthetic technique for you.

NAME Christine Keenan

TODAY'S DATE

General Health Excellent ☐ Good ☐ WEIGHT 250 HEIGHT 5'5" AGE 57 SEX F
Fair ☒ Poor ☐

Has anyone in your family:

Had a tendency to bleed excessively?

YES

NO

☐

☒

Had unexplained fevers during anesthesia?

☐

☒

Had any unusual reactions to anesthesia?

☐

☒

YOUR MEDICAL HISTORY	YES	NO	CHECK BOXES
Do you smoke?		<input checked="" type="checkbox"/>	Have you had surgery on the -
Do you drink alcoholic beverages?	<u>Very occasionally 2x/yr</u>		Neck <input checked="" type="checkbox"/> Jaw <input type="checkbox"/> Kidney <input type="checkbox"/>
Have you had a blood transfusion?		<input checked="" type="checkbox"/>	Abdomen <input checked="" type="checkbox"/> Thyroid <input checked="" type="checkbox"/> Breast <input type="checkbox"/>
Are you pregnant at this time?		<input checked="" type="checkbox"/>	Heart <input type="checkbox"/> Brain <input checked="" type="checkbox"/> Lung <input type="checkbox"/>
Are you allergic to any medications?	<input checked="" type="checkbox"/>		Other <u>Wrist, Wards, Back (lower)</u>
If yes, what?	<u>morphine</u>		Other <u>Lipomas - Several</u>

HAVE YOU EVER HAD...?	YES	NO	HAVE YOU EVER HAD...?	YES	NO
Heart Disease/Failure/Attack?	<input checked="" type="checkbox"/>		Thyroid Disease?	<input checked="" type="checkbox"/>	
Heart Murmur? Rheumatic Fever?		<input checked="" type="checkbox"/>	Diabetes Mellitus?	<input checked="" type="checkbox"/>	
High Blood Pressure?	<input checked="" type="checkbox"/>		Frequent Indigestion? Hiatal Hernia?	<input checked="" type="checkbox"/>	
Palpitations? (irregular heart beats)		<input checked="" type="checkbox"/>	Ulcers? Obstructions?		<input checked="" type="checkbox"/>
Chest Pain or Angina?	<input checked="" type="checkbox"/>		Easy Bruising/Bleeding Excessively?		<input checked="" type="checkbox"/>
Abnormal EKG?	<input checked="" type="checkbox"/>		Blood Disorders?		<input checked="" type="checkbox"/>
Stroke? (TIA - likely lipoma)	<input checked="" type="checkbox"/>		Glaucoma?		<input checked="" type="checkbox"/>
Abnormal Shortness of Breath?	<input checked="" type="checkbox"/>		Frequent Headaches?		<input checked="" type="checkbox"/>
Asthma or Wheezing?	<input checked="" type="checkbox"/>		Nerve Paralysis?		<input checked="" type="checkbox"/>
Emphysema?		<input checked="" type="checkbox"/>	Fainting Spells?		<input checked="" type="checkbox"/>
Bronchitis? Pneumonia?	<input checked="" type="checkbox"/>		Epilepsy? (seizures)		<input checked="" type="checkbox"/>
Tuberculosis?		<input checked="" type="checkbox"/>	Back Pain/Problems? Arthritis?	<input checked="" type="checkbox"/>	
Smoker's Cough?		<input checked="" type="checkbox"/>	Phlebitis?		<input checked="" type="checkbox"/>
Hay Fever?		<input checked="" type="checkbox"/>	Nervous or Psychiatric Disorder?		<input checked="" type="checkbox"/>
Hepatitis? Liver Disease?		<input checked="" type="checkbox"/>	Drug Addiction/Alcoholism?		<input checked="" type="checkbox"/>
Gallbladder Disease?	<input checked="" type="checkbox"/>		Serious Illness During Pregnancy?		<input checked="" type="checkbox"/>
Kidney Disease?	<input checked="" type="checkbox"/>		Motion Sickness?		<input checked="" type="checkbox"/>
Sickle Cell Anemia?		<input checked="" type="checkbox"/>	Other Illness not Mentioned? <u>Lipedema, Dermatitis, Lymphedema</u>		

DO YOU?	YES	NO	DO YOU HAVE...?	YES	NO
Wear removable dentures?		<input checked="" type="checkbox"/>	a false eye?		<input checked="" type="checkbox"/>
Contact lenses?		<input checked="" type="checkbox"/>	any loose/chipped teeth?		<input checked="" type="checkbox"/>
False eyelashes?		<input checked="" type="checkbox"/>	any physical/congenital defects?		<input checked="" type="checkbox"/>
Have porcelain caps on your teeth?		<input checked="" type="checkbox"/>	difficulty opening your mouth?		<input checked="" type="checkbox"/>
Have difficulty moving your head?		<input checked="" type="checkbox"/>	Cataracts?		<input checked="" type="checkbox"/>

ANESTHESIA HAD BEFORE?	YES	NO	YES	NO
Saddle/Spinal "Block"/Epidural	<input checked="" type="checkbox"/>		Local or nerve blocks?	<input checked="" type="checkbox"/>
General (completely asleep)	<input checked="" type="checkbox"/>		Have you had any unusual reactions, problems, or complications with anesthesia?	<input checked="" type="checkbox"/>
Pentothal		<input checked="" type="checkbox"/>		

MEDICATIONS: Please list names and doses of any medicines you take now or have taken within the last 6 months.

Oxycodone daily Am - Oxycodone 10/325 As needed -
Hydrochlorothiazide, daily, Am - Ketamine infusions, every 2 months,
Vitamin D 50K w/ly -

Patient or Guardian Signature: Christine Keenan

Date: 9/13/22

Physicians Signature: [Signature]

Date: 9/14/22

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MH / VTE RISK ASSESSMENT

Malignant Hyperthermia Risk Assessment:

Have you ever experienced any of the following?

Yes No

- ☐ ☒ Personal History of MH
- ☐ ☒ Family History of MH
- ☒ ☐ Unexplained Muscle Cramping or Spasms
- ☐ ☒ Excessive Sweating
- ☐ ☒ Night Sweats
- ☒ ☐ Fatigue
- ☒ ☐ Nausea or Motion Sickness
- ☐ ☒ Dizziness

Yes No

- ☒ ☐ Excessive Thirst
- ☒ ☐ Headaches
- ☐ ☒ Heatstroke
- ☒ ☐ Heat Intolerance
- ☒ ☐ Elevated Blood Pressure
- ☒ ☐ Hypothyroidism
- ☐ ☒ Fevers following exercise or anesthesia
- ☐ ☒ Dark (Chocolate) Colored Urine

EVER?

Please indicate how many caffeinated beverages you consume daily: 2-12oz

Family history of unexpected death(s) following general anesthesia or exercise? No ☒ If yes, please explain: _____

Do you have a muscle or neuromuscular disorder? No ☒ If yes, please explain: _____

VTE Risk Assessment: Time frame?

Add 5 points for each of the following statements that apply:

- ☐ Recent elective hip or knee joint replacement surgery
- ☐ Broken hip, pelvis, or leg within the last month
- ☐ Serious trauma within the last month (for example, a fall, broken bone, or car accident)
- ☐ Spinal cord injury with paralysis within the last month

Add 2 points for each of the following statements that apply:

- ☐ Age 60-74 years
- ☒ Cancer (current or previous)
- ☐ Recently had major surgery that lasted longer than 45 minutes
- ☐ Recent laparoscopic surgery longer than 45 minutes
- ☐ Plaster cast that has kept you from moving your limb within the last month
- ☐ Tube in blood vessel in neck or chest that delivers blood or medicine directly to the heart (also called central venous access)

Add 3 points for each of the following statements that apply:

- ☐ Age 75 or over
- ☐ History of blood clots
- ☐ Family history of blood clots
- ☐ Family history of blood-clotting disorders

Add 1 point for each of the following statements that apply:

- ☐ Use of birth control or Hormone Replacement Therapy
- ☐ Have been pregnant or had a baby within the last month
- ☒ Age 41-60 years
- ☐ Planning minor surgery in the near future
- ☐ Had major surgery within the past month
- ☐ Serious Infection (for example, pneumonia)
- ☒ Lung Disease (for example, emphysema or COPD)
- ☐ Varicose Veins
- ☒ History of inflammatory Bowel Disease (Crohn's, UC)
- ☒ Legs are currently swollen
- ☒ Overweight or obese
- ☐ Heart Attack

☐ History of Congestive Heart Failure ☐ Currently on bed rest or severely restricted mobility

Total Score: 6 Low Risk 0-1 point, Moderate Risk 2 points, High Risk 3+ points

Patient Signature

Date

Anesthesiologist Signature

Date

Surgeon Signature

Date

RN Signature

Date

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MEDICATION RECONCILIATION FORM

Patient Name:

Christine Keenan

Date:

9/13/22

Data source: ☐ Patient ☐ Family ☐ MD ☐ Pharmacies ☐ Provided H&P

Patients Pharmacy of choice:

Phone #

Allergies: Medications, Food, environmental, LATEX- indicate reaction

or

☐ No Known Allergies

Allergic to:	Reaction	Allergic to:	Reaction
1. Morphine	Anaphylactic Shock	3. Bee stings	Hives - slight Anaphylactic Shock
2. Adhesives (only over 72 hrs)	Burn	4.	

↳ only long term 72 hrs "4" - otherwise, Fine

List All Medications: including over the counter medications, herbal supplements, vitamins, minerals.

List those prescribed pre-operatively by surgeon.

To be completed for discharge

Name of Medication	Dosage	Frequency (When)	Route (how you take the medicine)	Check with primary care physician before resuming	Resume as pre-op	Change to:	Discontinue
Olmecartan		daily AM	oral				
Hydrochlorothiazide		daily AM	oral				
Gabapentin	600	3x day	oral				
Vitamin D	50K	Wkly	oral				
Enviva	-	Daily	oral				

↳ pre/probiotic

Post-OP Medications Orders:

☐ No Change; continue as listed above ☐ Add/New (see listed below) ☐ Change (see below) ☐ Discontinue (see below)

Name of Medication	Dosage	Frequency (When)	Route (how you take the medicine)	Name of Medication	Dosage	Frequency (When)	Route (how you take the medicine)
1.				4.			
2.				5.			
3.				6.			

PREOP RN:

J. Caydillo

D/C RN:

J. Caydillo

Physician:

[Signature]

Patient:

Christine Keenan

NOTE to Patient: Please take this medication list to your next doctor's appointment

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PHYSICIAN'S ORDERS

DATE	TIME	PRE OPERATIVE ORDERS AND INTRAOPERATIVE ORDERS (check all that apply)
9/14/22	8000	<input checked="" type="checkbox"/> Obtain baseline vital signs
		<input checked="" type="checkbox"/> Start IV T.K.O. with LR or NS
		<input checked="" type="checkbox"/> Antibiotic: <input type="checkbox"/> 1 gram Ancef I.V. given within 60 minutes of surgical start time
		<input checked="" type="checkbox"/> Antibiotic: 2 gram Ancef
		<input checked="" type="checkbox"/> Tumescant Solution: per preference Card
		<input checked="" type="checkbox"/> Procedure: Lipedema Reduction surgery to posterior legs, thighs + Right hip, Dercums Reduction surgery of abdomen with possible direct excision, liposuction and skin excision.
		<input checked="" type="checkbox"/> Valium 10 mg 1 tab po pre operatively
		<input checked="" type="checkbox"/> Fentanyl 12.5-25mcg IVP Q5-15 min PRN pain intraoperatively NTE 200mcg
		<input checked="" type="checkbox"/> Zofran 4mg IVP x 2 PRN nausea intraoperatively
		<input checked="" type="checkbox"/> Pre-Operative Labs: CBC, CMP, PTT, PT, UA fields Tests, HIV antibody, Hepatitis C titer, Hepatitis B Surface antigen
		<input checked="" type="checkbox"/> EKG
		<input type="checkbox"/> Finger stick blood glucose
Order Noted by RN Initials: J.C. PHYSICIAN SIGNATURE: _____		

DATE	TIME	POST OPERATIVE ORDERS: (check all that apply)
9/14/22	1109	<input checked="" type="checkbox"/> Vital signs every 5 minutes for the first 15 minutes, then every 15 minutes if stable until D/C
		<input checked="" type="checkbox"/> Continue the current I.V. solution @ _____ cc/Hr
		<input checked="" type="checkbox"/> Continue with IV solution until _____ ml given prior to discharge.
		<input checked="" type="checkbox"/> Discontinue I.V. when stable; after dressed without N/V
		<input checked="" type="checkbox"/> Discharge patient to aftercare facility with I.V., to be discontinued at aftercare facility
		<input checked="" type="checkbox"/> Oxygen @ 2-10 L/min via Cannula or Mask; PRN SOB O2 Sat < 92%. D/C O2 when stable, sitting without N/V/SOB
		<input checked="" type="checkbox"/> Apply ice packs to operative area
		<input checked="" type="checkbox"/> Elevate operative area
		<input checked="" type="checkbox"/> Void before discharge
		<input checked="" type="checkbox"/> Assess surgical site/ dressing every 15 minutes or more frequently as needed during recovery period until discharge
		<input checked="" type="checkbox"/> Activity: As tolerated with supervision
		<input checked="" type="checkbox"/> Diet: Advance as tolerated
		<input type="checkbox"/> Medications:
		<input checked="" type="checkbox"/> Pain Medication: @ 11:30am Percocet 5/325 mg, @ 12:20pm Gabapentin 600mg
		<input checked="" type="checkbox"/> Nausea Medication:
		<input type="checkbox"/> Other:
		<input type="checkbox"/> Discharge Patient to responsible adult when stable and meets all discharge criteria
Order Noted by RN Initials: J.C. PHYSICIAN/ ANESTHESIOLOGIST SIGNATURE: _____		

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

Pre- Operative Contact/ Notes:

Called patient. Instructed NPO 8 hours prior to surgery. Follow Pre-op instructions as directed by surgeon's office. Take pre-op medications if applicable as directed by surgeon. Instructed to have someone drive patient to and from the surgery center. Directions to surgery center given. Instructed to arrive at 0600, Patient verbalized good understanding of all instructions given. Patient contacted by: Gabi V.

NURSING NOTES:

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

Pre- Procedure checklist and Nursing Assessment

Age: 57 Sex: ☐ Male ☒ Female Patient identification: ☒ Verbal ☐ Chart ☐ Armband ☒ ID ☒ DOB
 Language Preference: ☒ English ☐ Spanish Other: ☐ _____
 Interpreter: ☒ No ☐ Yes Name of Translator: _____ Relationship to patient: _____
 Scheduled Procedure(s): LRS Posterior Legs, Thighs + Right Hip, Dercums Reduction Surgery abdomen with possible direct liposuction + skin excision
 BP: 149/65 HR: 60 Temp: 97.7 Resp: 19 SpO2: 96 Wt: 245 Ht: 5'5" Pain Level 0 /10
 I.V. Started: Right/Left: Hand with a 22 gauge needle, infusing LR/NS; site clear.
 Allergies/ Abnormal Reaction: ☐ NKA or Morphine, Benzodiazepines: anaphylactic
 Medications taken today prior to arrival: ☐ None, or: Tylenol 500mg, Gabapentin 300mg, Hydrochlorothiazide
 Skin Condition: ☒ Dry ☐ Warm ☒ Pink ☐ Pale ☐ Cyanotic ☐ Diaphoretic ☐ Other: _____
 Abdominal Assessment: ☐ Flat ☐ Soft ☐ Firm ☐ Tender ☐ Distended ☐ Other: _____
 Physical Limitations: ☒ None ☐ Visual ☐ Mobility ☐ Auditory ☐ Language ☐ Other: _____
 LOC: ☒ Alert ☒ Calm ☐ Oriented ☐ Confused ☐ Nonverbal ☐ Agitated ☐ Other: _____
 Cognitive Evaluation: ☐ Cognizant/ aware ☐ Confused/ Unaware ☐ Other: _____
 Glucose test: ☐ No ☐ Yes, Results: _____ Time: _____ MD/ Anesthesiologist Notified: ☐ Yes Orders give: ☐ No ☐ Yes
 Neurological Problems: ☐ Yes ☒ No Diabetes ☒ Yes ☐ No Hypertension ☒ Yes ☐ No
 Bleeding Problems: ☐ Yes ☒ No Hepatitis ☐ Yes ☒ No Asthma ☒ Yes ☐ No
 Fainting/ Dizziness: ☐ Yes ☒ No Smoking ☐ Yes ☒ No Heart Disease ☐ Yes ☒ No
 Other: _____

Prior surgeries: Panniculectomy (2020), Pineaal cyst/lipoma removal (2019), Gastric bypass (2015), Carpel tunnel (2014)
 Prior surgeries: Hysterectomy (2010), Thyroid removal (2004), L5-S1 (1986), Cholecystectomy (1985)
 Reactions to anesthesia: ☐ None or describe: _____

Pre-Op Meds Given	Time	Dose	Route	Initials	Note

Yes No N/A

PRE - PROCEDURE CHECKLIST:

/	/	/	1. Consents signed.	
/	/	/	2. History & Physical complete.	
/	/	/	3. Labs completed as ordered by physician.	
/	/	/	4. Physician notified of abnormal results	
/	/	/	5. Pregnancy Test: Results <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> N/A Lot # <u>HCG 1112056</u> exp: <u>2023-11-30</u> <input type="checkbox"/> Control result validated <input type="checkbox"/> Negative <input type="checkbox"/> Invalid If control result is invalid inform the Clinical Supervisor ASAP	
/	/	/	6. Physical assessment is unchanged since pre-admission evaluation	
/	/	/	7. Valuables (clothing, jewelry) <input type="checkbox"/> None <input checked="" type="checkbox"/> Removed <input type="checkbox"/> Retained	
/	/	/	8. Dentures/partial plates <input checked="" type="checkbox"/> None <input type="checkbox"/> Removed <input type="checkbox"/> Retained	
/	/	/	9. Contact lens/glasses <input type="checkbox"/> None <input checked="" type="checkbox"/> Removed <input type="checkbox"/> Retained	
/	/	/	10. Hearing aid <input checked="" type="checkbox"/> None <input type="checkbox"/> Removed <input type="checkbox"/> Retained	
/	/	/	11. Other belongings: <input checked="" type="checkbox"/> None <input type="checkbox"/> Removed <input type="checkbox"/> Retained	
/	/	/	12. Voided	
/	/	/	13. Discharge instructions reviewed with patient	
/	/	/	14. Patient reports nothing to eat or drink (including water) since: <u>9:30</u> am/pm Date: <u>9/13/22</u>	

Does the patient have an Advance Directive: ☐ No ☐ Yes If yes, Center policy explained to patient? ☐ Yes ☐ No
☐ Advance Directive Forms provided and in the chart

RN Signature: L. Candilla

Date: 9/14/22

Time: 0600 hrs

TLC Surgical Center
 240 S. La Cienega, Suite 210
 Beverly Hills, Ca 90211
 310-882-5454

KEENAN, CHRISTINE FEMALE
 DOB: 02/21/1965 DOS: 09/14/2022
 PHONE: (817)773-0435 MR#: 8252
 SURGEON: JAIME SCHWARTZ, MD

Dr. Jaime S. Schwartz, M.D., F.A.C.S
Board Certified Plastic & Reconstructive Surgeon

SURGEON: Dr. Jaime S. Schwartz, MD FACS

PATIENT NAME: Christine Keenan

DOB: 02/21/1965

SURGERY: - Lipedema Posterior Legs (Bilateral)
- Lipedema (Lipedema Reduction - Abdomen)

DATE OF SURGERY: 09/14/2022

Anesthesia:

General

Local

REQUEST FOR PRE-OPERATIVE TESTS

I request the following clearance, bloodwork, and any applicable tests to be completed no later than 21 days prior to the surgery date. If not completed and received within 21 days of surgery, surgery may be postponed at additional cost.

Please fax the patients completed medical clearance with all lab results to (310) 747-5908.

Any questions please call (310) 882-5454.

- Medical Clearance
- DVT Prophylaxis Recommendation (see page 2)
- CBC
- COAGS (PT/ PTT/ INR)
- CMP
- LFT
- Prealbumin
- HbA1c
- B-HCG (FEMALES)
- Urinalysis w/ C & S
- EKG
- Mammogram (All women ages 40+)
- Abdominal Ultrasound (rule out ventral, umbilical or previous surgical site hernia)
- Chest Xray
- Covid Test (Must be done 48 hours prior to surgery)
- Any other relevant tests based on patient's medical history

ADDITIONAL TESTING:

- Cardiac Clearance

Dr. Jaime S. Schwartz, M.D., F.A.C.S
Board Certified Plastic & Reconstructive Surgeon

Physical Examination

AGE: 57 SEX: F HEIGHT: 65 inch WEIGHT: 248 lb.
BP: 134/88 PULSE: 67/min RESP: 18 TEMP: 97.0

GENERAL APPEARANCE AND SKIN:

HEAD AND NECK: Normal

LABS:

ENT:

EKG:

THORAX & BREAST:

CXR:

LUNGS:

MSK: Normal

CV:

NEURO: Normal

ABDOMEN:

GENITALIA:

IMPRESSION:

RECOMMENDATIONS:

*Our standard DVT prophylaxis includes the following:

1. High-high TED hose placed in pre-op holding and worn for 1 week post-op
2. Knee-high SCDs placed pre-op and worn through discharge from PACU (if outpatient) or continuously at rest (if inpatient) until hospital discharge
3. Early ambulation post-op

*DVT PROPHYLAXIS USED:

Standard:

Other Chemical e.g. Lovenox, Xarelto): _____ Days: _____
(IF "LOVENOX" IS PREFERRED, PLEASE SPECIFY YOUR RECOMMENDATIONS FOR DURATION OF TIME.)

*PATIENT CLEARED FOR SURGERY:

YES

NO

MD SIGNATURE: Jaime S. Schwartz

DATE: 08/16/2022

MD NAME (printed): _____

Dr. Jaime S. Schwartz, M.D., F.A.C.S
Board Certified Plastic & Reconstructive Surgeon

- Pulmonary Clearance

Medical Clearance for Surgery

Please complete the following medical history and physical. Fill in the form legibly or please type. Unless otherwise noted, this must be received by our office a minimum of 21 days before surgery.

CHIEF COMPLAINT:

PREOP CLEARANCE

ALLERGIES, DRUG SENSITIVITIES:

Morphine, Bee sting.

REVIEW OF SYSTEMS:

PULM: Neg.

GU: Neg.

CV: Neg.

GYN: Neg.

GI: Neg.

NEURO: Neg.

PAST MEDICAL/SURGICAL HISTORY: (SURGERIES, ILLNESSES, ETC.)

• TOBACCO USE: None

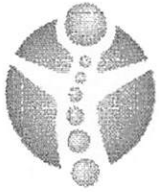
• ALCOHOL USE: None

• BLEEDING TENDENCIES: None

• TRANSFUSIONS: None

• CURRENT MEDICATIONS: PIS. See list-

(please include medications that are recommended to be stopped prior to surgery and if so when)



Houston MRI® & Diagnostic Imaging

Sugar Land
15555 Creek Bend Dr Ste. 300
Sugar Land, TX 77478
Phone: (713) 425-8117

DIAGNOSTIC IMAGING REPORT

Keenan, Christine

MRN: 1156488 Acc: 12181300
DOB: 02-21-1965 Sex: F

Date of Service: 08-16-2022

Referring Provider:

AMBER KAZI MD
17228 W. Grand Parkway South, Ste. 2010
Sugar Land Texas 77479
Phone: (832) 841-4001

Exam: XRAY CHEST 2V

EXAM: XRAY CHEST - 2 Views

CLINICAL INDICATION: Preoperative screening.

TECHNIQUE: PA and lateral views of the chest.

COMPARISON: None

FINDINGS: Lung fields appear clear without evidence of consolidation. There are no abnormal pulmonary infiltrates, effusions, nodules or masses. The cardiac silhouette is normal in size and contour. Hilar and mediastinal structures do not show any abnormal mass or lymphadenopathy. No x-ray abnormality of the spine, ribs or extra thoracic skeletal structures. Extrathoracic soft tissues are unremarkable.

IMPRESSION: No x-ray abnormality of the chest.

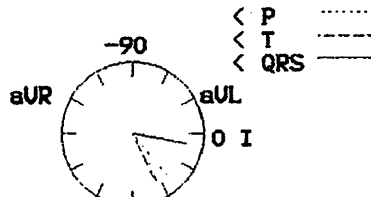
Thank you for the opportunity to participate in the care of this patient.

Matthew Murray MD, DABR
Diagnostic Radiologist
Electronically Signed: 08-17-2022 9:07 PM

PHYSICIANS AND HEALTHCARE PROVIDERS ONLY: For questions regarding the content of this report, call 866-674-9729 or email PACShelp@houstonmri.com or on our Provider Portal <https://doctorportal.houstonmri.com/>

Measurement Results:

QRS 70 ms
QT/QTcB 416 / 411 ms
PR 188 ms
P 108 ms
RR/PP : 1008 / 1015 ms
P/QRS/T : 50/ 11/ 63 degrees



Interpretation:

12SL - Interpretation:
Sinus bradycardia
Low voltage QRS
Inferior infarct , age undetermined

CHRISTINE KEENAN
D.O.B. 02/21/1965
D.O.S. 08/16/2022
Dr. Amber Kazi M.D.

Unconfirmed report

Cart 3 Sheet 1

Aug/16/2022 11:45:56 25mm/s 20mm/mV ADS 60Hz 0.08 - 150Hz 4x2.5x1 12 Lead U6-11-M121-023 12SL0V281

KEENAN, CHRISTINE T, 57 Y, F, 02/21/1965

817-773-0435

CUMULATIVE REPORTS

Prealbumin

COLLECTION DATE	08/16/2022	05/16/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Prealbumin	21.1 20.0-40.0 mg/dL	19.3L 20.0-40.0 mg/dL	21.9 20.0-40.0 mg/dL

Hemoglobin A1C

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Hemoglobin A1C	5.8H <5.7 %	5.2 <5.7 %	5.1 <5.7 %	5.1 <5.7 %

Comprehensive Metabolic Panel (CMP)

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
A/G Ratio	1.8 1.1-2.5 mg/dL	2.0 1.1-2.5 mg/dL	1.7 1.1-2.5 mg/dL	1.8 1.1-2.5 mg/dL
Albumin	4.4 3.5-5.3 g/dL	4.4 3.5-5.3 g/dL	3.8 3.5-5.3 g/dL	4.2 3.5-5.3 g/dL
Alkaline Phosphatase	80 35-121 IU/L	72 35-121 IU/L	69 35-121 IU/L	83 35-121 IU/L
ALT (SGPT)	14 <5-47 IU/L	15 <5-47 IU/L	14 <5-47 IU/L	20 <5-47 IU/L
AST (SGOT)	23 <5-40 IU/L	27 <5-40 IU/L	20 <5-40 IU/L	22 <5-40 IU/L
Bilirubin, Total	0.6 <0.2-1.2 mg/dL	0.4 <0.2-1.2 mg/dL	0.4 <0.2-1.2 mg/dL	0.4 <0.2-1.2 mg/dL
BUN	53H 6-20 mg/dL	21H 6-20 mg/dL	29H 6-20 mg/dL	36H 6-20 mg/dL
Calcium	9.5 8.6-10.4 mg/dL	9.2 8.6-10.4 mg/dL	8.9 8.6-10.4 mg/dL	9.4 8.6-10.4 mg/dL
Chloride	106 97-108 mEq/L	108 97-108 mEq/L	110H 97-108 mEq/L	105 97-108 mEq/L
CO2	19L 22-32 mEq/L	20L 22-32 mEq/L	21L 22-32 mEq/L	24 22-32 mEq/L
Creatinine	1.79H 0.50-1.00 mg/dL	1.24H 0.50-1.00 mg/dL	1.11H 0.50-1.00 mg/dL	1.36H 0.50-1.00 mg/dL
Glucose	121H 65-99 mg/dL	84 65-99 mg/dL	95 65-99 mg/dL	101H 65-99 mg/dL
Potassium	4.6 3.5-5.3 mEq/L	4.9 3.5-5.3 mEq/L	5.3 3.5-5.3 mEq/L	4.9 3.5-5.3 mEq/L
Sodium	140 135-145 mEq/L	142 135-145 mEq/L	143 135-145 mEq/L	140 135-145 mEq/L
Protein	6.8 6.0-8.3 g/dL	6.6 6.0-8.3 g/dL	6.1 6.0-8.3 g/dL	6.6 6.0-8.3 g/dL

CBC With Platelet And Differential

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Basophils Automated	0.6 0.0-1.5 %	0.5 0.0-1.5 %	0.7 0.0-1.5 %	0.8 0.0-1.5 %
Eosinophils Automated	2.8 0.0-8.0 %	2.3 0.0-8.0 %	3.7 0.0-8.0 %	2.4 0.0-8.0 %
Hematocrit (HCT)	45.5 35.2-46.4 %	41.8 35.2-46.4 %	37.6 35.2-46.4 %	41.0 35.2-46.4 %
Hemoglobin (Hgb)	15.1 11.5-15.5 gm/dL	13.8 11.5-15.5 gm/dL	11.9 11.5-15.5 gm/dL	13.8 11.5-15.5 gm/dL
Immature Granulocyte Automated	0.2 0.0-1.0 %	0.4 0.0-1.0 %	0.0 0.0-1.0 %	0.0 0.0-1.0 %
Lymphocytes Automated	38.3 14.0-48.0 %	32.4 14.0-48.0 %	40.0 14.0-48.0 %	40.4 14.0-48.0 %
MCH	29.4 26.9-35.0 pg	30.1 26.9-35.0 pg	30.6 26.9-35.0 pg	31.1 26.9-35.0 pg
MCHC	33.2 30.4-34.8 g/dL	33.0 30.4-34.8 g/dL	31.6 30.4-34.8 g/dL	33.7 30.4-34.8 g/dL
MCV	88.5 79.0-99.0 fL	91.3 79.0-99.0 fL	96.7 79.0-99.0 fL	92.3 79.0-99.0 fL
Monocytes Automated	8.0 4.0-13.0 %	8.2 4.0-13.0 %	7.7 4.0-13.0 %	7.1 4.0-13.0 %
Platelet Count	273 137-397 K/cumm	244 137-397 K/cumm	321 137-397 K/cumm	266 137-397 K/cumm
Red Blood Cell Count (RBC)	5.14 3.60-5.30 M/mm3	4.58 3.60-5.30 M/mm3	3.89 3.60-5.30 M/mm3	4.44 3.60-5.30 M/mm3
RDW	43.4 38.6-53.8 fL	40.4 38.6-53.8 fL	44.4 38.6-53.8 fL	42.8 38.6-53.8 fL
Neutrophils Automated	50.1 41.0-77.0 %	56.2 41.0-77.0 %	47.9 41.0-77.0 %	49.3 41.0-77.0 %
WBC	5.3 3.8-11.5 K/uL	5.6 3.8-11.5 K/uL	4.6 3.8-11.5 K/uL	5.1 3.8-11.5 K/uL

FROM: PRA LATION
PRA: 2022000000
10.
Urinalysis (UA) with reflex to Microscopic and Culture

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Urine Appearance	Clear Clear	CLEAR CLEAR	CLEAR CLEAR	CLEAR CLEAR
Urine Bilirubin	Negative Negative	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine Blood	Negative Negative	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine Color	Yellow Yellow	DK YELLOW YELLOW	YELLOW YELLOW	YELLOW YELLOW
Urine Glucose	Negative Negative	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine Ketones	Negative Negative	TRACEA NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine Leukocytes Esterase	Negative Negative	NEGATIVE NEGATIVE	TRACEA NEGATIVE	NEGATIVE NEGATIVE
Urine Nitrites	Negative Negative	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine pH	5.5 5.0-9.0	5.0 5.0-9.0	5.5 5.0-9.0	6.0 5.0-9.0
Urine Protein	Negative Negative	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE	NEGATIVE NEGATIVE
Urine Specific Gravity	1.021 1.005-1.030	1.026 1.005-1.030	1.021 1.005-1.030	1.021 1.005-1.030
Urine Type	Clean Catch	Clean Catch	Clean Catch	Clean Catch
Urine Urobilinogen	1.0 0.2-1.0 E.U./dL	1.0 0.2-1.0 E.U./dL	0.2 0.2-1.0 E.U./dL	0.2 0.2-1.0 E.U./dL

Beta-hCG Qualitative Serum

COLLECTION DATE	05/16/2022	02/24/2022
Order Date	08/16/2022	02/24/2022
Result Date	08/17/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER
Beta-hCG Qualitative Serum	Negative Negative	Negative Negative

PT/PTT Panel

COLLECTION DATE	08/16/2022	05/16/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
INR	1.1 0.9-1.2	1.0 0.9-1.2	1.0 0.9-1.2
PT	10.9 9.5-12.2 sec	10.3 9.5-12.2 sec	10.2 9.5-12.2 sec
Partial Thromboplastin Time (PTT)	31.0 23.9-33.0 sec	27.6 23.9-33.0 sec	28.4 23.9-30.0 sec

Estimated Glomerular Filtration Rate

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Estimated GFR (Black)	36L >59 mL/min/1.73m2	56L >59 mL/min/1.73m2	64 >59 mL/min/1.73m2	50L >59 mL/min/1.73m2
Estimated GFR (Other)	31L >59 mL/min/1.73m2	48L >59 mL/min/1.73m2	55L >59 mL/min/1.73m2	43L >59 mL/min/1.73m2

Estimated Average Glucose

COLLECTION DATE	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Order Date	08/16/2022	05/16/2022	04/08/2022	02/24/2022
Result Date	08/17/2022	05/17/2022	04/13/2022	02/25/2022
Ordering Physician	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER	KAZI, AMBER
Estimated Average Glucose	120 mg/dL	103 mg/dL	100 mg/dL	100 mg/dL

Beta-hCG, Serum, (Quantitative)

COLLECTION DATE	05/16/2022
Order Date	05/16/2022
Result Date	05/17/2022
Ordering Physician	KAZI, AMBER
Beta-hCG, Serum, (Quantitative)	2.5 mIU/mL

TSH reflex to FT4

COLLECTION DATE	04/08/2022
Order Date	04/08/2022
Result Date	04/13/2022
Ordering Physician	KAZI, AMBER
TSH reflex to FT4	2.23 0.27-4.20 mU/L

Lipid Panel

COLLECTION DATE	04/08/2022
Order Date	04/08/2022
Result Date	04/13/2022
Ordering Physician	KAZI, AMBER
Cholesterol / HDL Ratio	3.14 0.00-4.44 Ratio
Cholesterol	160 <200 mg/dL
HDL Cholesterol	51 >39 mg/dL
LDL Cholesterol (Calculation)	94 <130 mg/dL
LDL/HDL Ratio	1.8 <3.3 Ratio
Non-HDL Cholesterol	109 <130 mg/dL
Triglycerides	75 <150 mg/dL

Vitamin D 25-Hydroxy

COLLECTION DATE	04/08/2022
Order Date	04/08/2022
Result Date	04/13/2022
Ordering Physician	KAZI, AMBER
Vitamin D 25-Hydroxy	35.0 30.0-100.0 ng/mL

Urinalysis, Microscopic only

COLLECTION DATE	04/08/2022
Order Date	04/08/2022
Result Date	04/13/2022
Ordering Physician	KAZI, AMBER
Urine Bacteria	NONE SEEN NONE SEEN /HPF
Urine Casts	0-2 Hyaline 0-2 Hyaline /LPF
Urine Epithelial Cells	0-2 0-2 /HPF
Urine RBC	0-2 0-2 /HPF
Urine WBC	5-10A 0-2 /HPF

Culture, Urine

COLLECTION DATE	04/08/2022
Order Date	04/08/2022
Result Date	04/13/2022
Ordering Physician	KAZI, AMBER
Specimen Source	Urine
Culture, Urine	See Below
Sensitivity Panel	See Below
Klebsiella pneumoniae	15,000-25,000 CFU/ml Klebsiella pneumoniae

6750 West Loop South
Suite 855
Bellaire, TX 77401

September 7, 2022

Jaime S Schwartz, MD
240 South La Cienega, Suite 200
Beverly Hills, CA 90211

Dear Dr Schwartz:

I received your correspondence dated August 31, 2022 regarding our mutual patient, Ms Christine Keenan. I understand she is to undergo surgery on September 14, 2022. As you may be aware, she is a 57 year old woman with morbid obesity, gastric bypass surgery, ulcerative colitis, irritable bowel syndrome, fibromyalgia, hypertension with hypertensive kidney disease, diabetes mellitus type II with renal manifestations, mixed hyperlipidemia, secondary hyperparathyroidism due to renal disease, lymphedema, gastroesophageal reflux disease, gout, spinal stenosis, degenerative disk disease, cholecystectomy, hysterectomy. She quit smoking cigarettes.

I have recently been seeing her for chronic kidney disease stage IIIA.

From my perspective, there are no contraindications to the proposed surgery.

Thank you for your correspondence. If you should have any questions or concerns, please do not hesitate to contact me by telephone: (713) 461-1234 or email: 610kidney@gmail.com .

Sincerely,

A handwritten signature in black ink, appearing to read 'Elson Thomas', with a stylized flourish at the end.

Elson Thomas, MD

Perioperative Nursing Care Plan / Record															
Date 9/14/22	OR # PR #	Wound Classification I													
Surgeon Dr. Schwartz		Assistant N/A	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th>From</th> <th>To</th> </tr> <tr> <td>Time in O.R.</td> <td>0645</td> <td>1109</td> </tr> <tr> <td>Anesthesia</td> <td>0645</td> <td>1119</td> </tr> <tr> <td>Surgery</td> <td>0726</td> <td>1108</td> </tr> </table>		From	To	Time in O.R.	0645	1109	Anesthesia	0645	1119	Surgery	0726	1108
	From	To													
Time in O.R.	0645	1109													
Anesthesia	0645	1119													
Surgery	0726	1108													
Scrub Tech J. Manzanarez		Circulator L. Caudillo	Anesthesiologist L. Johnson												
Pre-op Dx: <u>lipedema pericumbis</u>															
Procedure <u>Lipedema Reduction Surgery to posterior legs, thighs + right hip, deruums</u> <u>Reduction surgery of abdomen with possible direct excision/ liposuction + skin excision</u>															
Postop Dx: <u>SAME</u>															
<input checked="" type="checkbox"/> X-Ray <input checked="" type="checkbox"/> X N/A <input type="checkbox"/> Radiograph <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Total Exposure Time:		TUMESCENT SOLUTION: <u>30mL lidocaine 2 Epi, 60mL</u> <u>Ropivacaine, 3mL Epinephrine</u> <u>3mL TAA</u>													
Drains, Packing <input checked="" type="checkbox"/> X N/A Type <u>JP 10FR x4</u> Site <u>thigh, posterior thigh</u> Specimens <input checked="" type="checkbox"/> X N/A		<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Posterior </div> <div style="text-align: center;"> Anterior </div> </div>													
Medications / Injectable <input type="checkbox"/>															
TOTALS IN: <u>5398 cc</u> OUT: <u>2500 cc</u> BLOODY:															
Departure Status L.O.C <input checked="" type="checkbox"/> Awake/oriented <input type="checkbox"/> Sedated/responds to verbal stimuli <input type="checkbox"/> Sedated/responds to pain stimuli <input type="checkbox"/> Unresponsive <input checked="" type="checkbox"/> Report given to PACU R.N.		Counts Initial: <u>X</u> Correct <u>X</u> Correct <u>X</u> Correct <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> N/A <input type="checkbox"/> N/A <input type="checkbox"/> N/A Closing: <u>X</u> Correct <u>X</u> Correct <u>X</u> Correct <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> N/A <input type="checkbox"/> N/A <input type="checkbox"/> N/A Final: <u>X</u> Correct <u>X</u> Correct <u>X</u> Correct <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> Incorrect <input type="checkbox"/> N/A <input type="checkbox"/> N/A <input type="checkbox"/> N/A													
Codes For Placement <input type="checkbox"/> ESU Pad ▲ EKG ▲ Tourniquet + B/P = Safety Straps • Pulse OX X IV Prep Area Shaded															
NURSES NOTES Patient taken to the operating room. <input checked="" type="checkbox"/> Monitors explained and applied. <input checked="" type="checkbox"/> Patient positioned- area prepped and draped in usual sterile fashion. <input checked="" type="checkbox"/> Ted hose with pneumatic compression: <input type="checkbox"/> yes <input type="checkbox"/> no <input checked="" type="checkbox"/> N/A Foley catheter: <input checked="" type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Tolerated procedure well. Incision(s) clean and dry. <input checked="" type="checkbox"/> Symmetry: <input type="checkbox"/> yes <input type="checkbox"/> no Hematoma: <input type="checkbox"/> present <input checked="" type="checkbox"/> absent Drains: <input checked="" type="checkbox"/> JP <input type="checkbox"/> Penrose <input checked="" type="checkbox"/> X N/A draining <input type="checkbox"/> clear <input type="checkbox"/> bloody <input checked="" type="checkbox"/> serosanguinous // location Ointment: <input checked="" type="checkbox"/> bacitracin <input type="checkbox"/> betadine <input type="checkbox"/> neosporin <input type="checkbox"/> N/A Dressings: <input type="checkbox"/> xeroform <input type="checkbox"/> adaptive <input type="checkbox"/> face cotton <input type="checkbox"/> 4X4 <input type="checkbox"/> ABD pad <input type="checkbox"/> kerlix <input type="checkbox"/> bias <input type="checkbox"/> bandaid <input type="checkbox"/> elastoplast <input type="checkbox"/> coban <input type="checkbox"/> other <input type="checkbox"/> N/A Cast: <input type="checkbox"/> yes Type <input checked="" type="checkbox"/> no <input checked="" type="checkbox"/> N/A Garments: <input checked="" type="checkbox"/> compression garment, LIPOSUCTION GARMENT TYPE : Fluids: <input checked="" type="checkbox"/> IV <input type="checkbox"/> Heparin Lock <input checked="" type="checkbox"/> LR <input type="checkbox"/> D5LR <input type="checkbox"/> NS <input type="checkbox"/> D5 45 NS <input type="checkbox"/> D5W infusing well at KVO. To recovery room in stable condition.															
R.N. Signature(s) <u>L. Caudillo</u>															

TLC Surgical Center
 240 S. La Cienega, Suite 210
 Beverly Hills, Ca 90211
 310-882-5454

KEENAN, CHRISTINE FEMALE
 DOB: 02/21/1965 DOS: 09/14/2022
 PHONE: (817)773-0435 MR#: 8252
 SURGEON: JAIME SCHWARTZ, MD

SURGICAL SAFETY CHECKLIST

Before induction of anesthesia with the nurse and anesthesiologist present.

- Has patient confirmed his/her identity, site, procedure, consent? ☒ Yes
- Is the surgical site marked ☒ Yes ☐ N/A
- Is the anesthesia machine and medications check complete? ☒ Yes
- Is the pulse oximeter on the patient and functioning? ☒ Yes
- Does the patient have a known allergy? ☒ Yes ☐ No
- If yes, what: Morphine / bee stings
- Does the patient have a difficult airway or aspiration risk? ☐ Yes ☒ No
- If yes, is there equipment/ assistance available? ☐ Yes
- Is there risk of more than 500ml blood loss? ☐ Yes ☒ No
- If yes, are there two IV's and additional fluids planned? ☐ Yes

Before skin incision with nurse, surgeon and anesthesiologist present.

- You have called a TIME OUT: ☒ Yes
- Identified all team members, confirmed patient's name, procedure, location where incision will be performed.
- Has antibiotic prophylaxis been given within last 60 minutes? ☒ Yes @ _____ ☐ N/A
- Have you anticipated critical steps of procedure? ☒ Yes
- Have you anticipated how long the case will take? ☒ Yes _____
- Does anesthesiologist have any patient specific concerns? ☐ Yes ☒ No
- Are there any equipment issues or concerns? ☐ Yes ☒ No
- Has sterility of all surgery related items been confirmed? ☒ Yes ☐ No
- Is essential imaging displayed? ☒ Yes ☐ N/A

Before patient leaves OR with nurse, surgeon, anesthesiologist present

- Nurse verbally confirms procedure and count: ☒ Yes
- name of procedure, instrument, needle, sponge count
- Specimen has been labeled with patient's name? ☐ Yes ☒ N/A
- What key concerns for recovery and management of patient? ☒ N/A
- _____
- _____
- _____
- _____

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

KEENAN, CHRISTINE FEMALE
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PHONE: (817)773-0435 MR#: 8252
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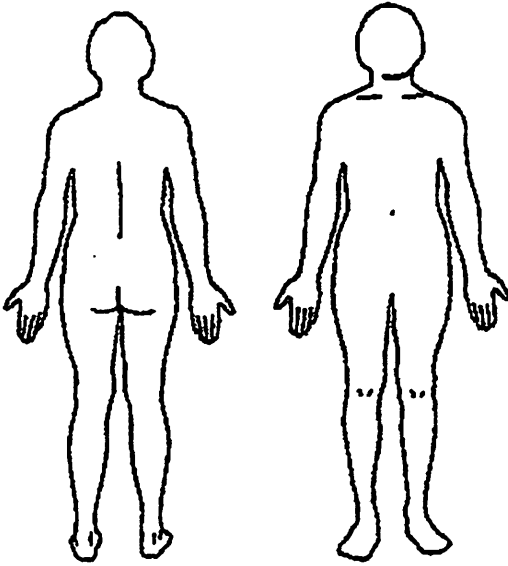
TLC Surgical Center
TREATMENT RECORD

DATE: 9/14/20

TUMESCENT IN: 5398cc

TOTAL OUT: 2500

TOTAL LIQUID OUT: 100



NOTES:

	In	out
R.Calf	580cc	400cc + 50cc extracted
L.Calf	750cc	500cc + 75cc extracted
R.Thigh	1160	200cc
L.Thigh	1300	500cc
Abd	1600	900cc

tissue 1 lb.

☐ VASER

BODY AREA	SIDE	PERCENT	V/C	TIME

BODY AREA	SIDE	PERCENT	V/C	TIME

☐ BODY TITE

BODY AREA	SIDE	INT CUTOFF	EXT CUTOFF	KJ DELIVERED	TIME

BODY AREA	SIDE	INT CUTOFF	EXT CUTOFF	KJ DELIVERED	TIME

☐ FAT TRANSFER

BODY AREA	AMOUNT INJECTED

BODY AREA	AMOUNT INJECTED

KEENAN, CHRISTINE FEMALE
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SURGEON: JAIME SCHWARTZ, MD

TLC Surgical Center

Page 1 of 2

ANESTHESIA START 0645 TIME IN OR 0645 TIME OUT 0725 SURGERY START 0726 SURGERY STOP 1100 TIME OUT OF OR 1109 ANESTHESIA STOP 1119		PRE-OP: BP: 149/85 HR: 90 RR: 16 SPO2: 95% ASA: 1 2 3 4 ALLERGIES: Morphine	DATE: 09/14/22 SURGEON: Schwartz Proposed Procedure: LPS Post. Fgs, Mighs, hips Pelvicus reduction abdomen + pos) excision EKG: LBBB CXR: WNL PMH: Obesity, Depression, Anxiety, HTN, CKD3, Gerd, chemo, Mxrtv/depression, U.C., hypothyroid
--	--	--	--

TIME:	07	30	00	30	00	30	TOTALS:
OXYGEN % L/min	10	2	2	2	2	2	
SEVO % ET							
PROPOFOL mcg/kg/min	2.5	2.0	1.5				
PROPOFOL mg	200						
LIDOCAINE mg	100						
KETAMINE mg	20/30						Ketamine 80 mg
MAGNESIUM mg	40						
PRECEDEX mcg	2						
VERSED mg	50						VERSED 2 mg
ROC/SUX mg							
FENTANYL mg							
DECADRON mg							
ZOFRAN mg							
NEOSTIG / BRIDION mg							
GLYCOPYRRELATE mg							
DEPCID	20						
Ephedrine		10/10					
ANCEF mg		2-4					
EKG	UR	UR	UR	UR	UR	UR	
O2 Saturation %	95	97	97	97	97	97	
ETCO2	30	35	36	35	31	24	
Temp °C/F	98.1				97.1	97.2	
PATIENT POSITION	U	O	O	O	O	O	
PRE-INDUCTION:							
HR	67						
BP	140/79						
SPO2	95%						
TEMP							
POST-OP:							
HR	71						
BP	153/79						
SPO2	99% 06 PM						
TEMP	97.3						
REPORT TO:	Leah						
FLUIDS LR							
TUBS	450/20	430/23	010/22	430/20			2200 mL
URINE OUTPUT							200 mL
EBL							5 mL

NOTES: Pt 10d/10d Hx/10d v. To DL, PreO2 25 min, IV start v, ASA Monitor v. JVI, OI typed v, Easy mask, Abdominal Intubation. Pt positioned prone by team - all pop v, all pink 40°/neutral/aligned. Exo/pose FFP. Procedure done. Pt turned prone by team. Pt w/ SV, TUP 4/4 - fully reversed; all criteria met. Pt suctioned/Extubated. Airway patent, US. To PACU. Report to RN.

ANESTHESIA PROVIDER: CRNA L. Johnson Date: 09.14.22 Procedure: LPS post fgs / mighs / hips PPS abdomen

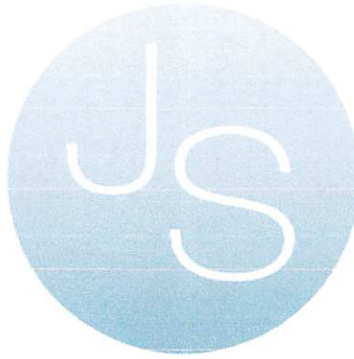
KEENAN, CHRISTINE FEMALE
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 SURGEON: JAIME SCHWARTZ, MD

TLC SURGICAL CENTER

Page 2 of 2

TIME: 0045 (10) - 20 - (11)		TOTALS:
OXYGEN % L/min	21 - 21 - 21 - 10	
SEVO % ET		
PROPOFOL mg/kg/min	0.0 - 0.0 - 0.0 - 0.0	
PROPOFOL mg		
LIDOCAINE mg		
KETAMINE mg		
MAGNESIUM mg		
PRECEDEX mg		
VERSED mg		
ROC / SUX mg		
FENTANYL mg		
DECADRON mg		
ZOFRAN mg		
NEOSTIG / BRIDION mg		
GLYCOPYRRELATE mg		
ANCEF mg		
EKG		
O2 Saturation %	98 - 98 - 98 - 98	
EtCO2	32 - 32 - 32 - 32	
Temp C/F	37.0 - 37.0 - 37.0 - 37.0	
PATIENT POSITION	Sup - Sup - Sup - Sup	
FLUIDS OR		
URINE OUTPUT		
ESL		
NOTES:		
<p>Y. J. CRANT L. Johnson</p>		
ANESTHESIA PROVIDER		DATE

09.14.22
 KEENAN, CHRISTINE FEMALE
 DOB: 02/21/1965 DOS: 09/14/2022
 PHONE: (817)773-0435 MR#: 8252
 SURGEON: JAIME SCHWARTZ, MD



TLC Surgical Center

240 S Laci enaga Blvd

Suite 210

Beverly Hills, CA 90211

NAME: Christine Keenan

DATE OF PROCEDURE: Wednesday, September 14th, 2022

PREOPERATIVE DIAGNOSIS: Lipedema

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Lipedema Reduction Surgery of Posterior Legs, Thighs, Saddle Bags, Dercums Reduction of Abdomen with Possible direct Excision, Liposuction and Skin Excision

SURGEON: Jaime S Schwartz, MD FACS

ANESTHESIOLOGIST: Lauren Johnson, CRNA

ANESTHESIA: TIVA

PREOPERATIVE MEDICATIONS: Ancef 2gms prior and 1gm q4 during procedure

ESTIMATED BLOOD LOSS: Minimal

FINDINGS: None

SPECIMEN: None

COMPLICATIONS: None

DISPOSITION: Stable to recovery care unit.

INDICATIONS FOR PROCEDURE:

Christine Keenan is a 57 year old female who has severe Lipedema. The untreated areas of lipedema has created increasing pain, dysmobility and interference with Activities of Daily Living (ADLs). The clinical symptoms include easy bruising, pain with walking, increasing fibrosis, swelling and masses. There has not been long-term improvement with diet, weight loss and other conservative therapies such as MLD and compression. The masses have been increasing in size and become much more tender to palpation including interfering with wearing certain clothing such as compression garments which are part of the recommended treatment guidelines for

Lipedema. The concerns in the increase and interference with long-term Lipedema treatment due to increase in size warrant removal Lipedematous fat and nodules via Manual Lipedema Extraction (MLE) and Lymphatic Sparing Liposuction technique so as to not increase risk of further fibrosis or lymphatic dysfunction. Risks, Benefits and Alternatives including but not limited to damage to neurovascular structures, seroma, infections as well as recurrence were discussed with the patient in the office and an informed consent was obtained.

RISKS:

The patient was seen in the preoperative area with the OR nurse and a chaperone if indicated as well as preoperative photographs. The patient performed surgical site confirmation in a mirror and concurred with the markings. These were then photographed.

The risks, benefits, expectations and alternatives of were discussed with the patient including, but not limited to, infection, bleeding, deep injury to nerves, blood vessels or other structures such as distal digits, injury to abdominal or thoracic viscera, seroma, deep venous thrombosis, delayed healing, visible scarring, contour irregularities, color change, asymmetry, loss of skin, cosmetic dissatisfaction, recurrence, development or worsening of Lymphedema, blood loss, vasovagal symptoms, scarring at incisions, anesthesia reaction, dysesthesia, as well as unplanned return to the operating room. Complication risk is higher if any of the treatment areas have had previous interventions. The patient read and signed the consent form and verbalized full understanding.

PROCEDURE:

Under full, informed consent, the patient was brought to the operating room. A Bair hugger was applied to keep the patient warm. TED hose and SCDS were applied to the lower extremities bilaterally for DVT prophylaxis prior to induction of anesthesia. Full continuous cardiac monitoring and automated blood-pressure measurements were performed per protocol. The patient was placed in the supine (with the arms outstretched) position. The patient underwent administration of anesthesia. The patient was then placed in the prone position carefully padding all contact points.

Surgical site preparation and draping was performed in standard sterile fashion. A Time-out was performed per protocol verifying the names of the patient and surgeon, the operative sites, and the operative plan per the informed consent. All staff in the room verified the information and site(s) as correct. Universal PAUSE Rule was fulfilled.

Incisions were made and tumescent solution was infiltrated into the treatment area evenly until satisfactory tissue turgor was achieved. After an appropriate amount of time Lipedematous fat was removed with skin protective cannulas from superficial to deep. Once the softer, more mobile fat was removed, the firmer, larger and non-mobile Lipedema nodules were bluntly removed until the treated areas were softer and smoother. The areas were then reirrigated with tumescent solution. All fluid was

them milked out of the incisions. Drains were placed if indicated. The incisions were closed in layers as well as covered with a waterproof dressing. Compression garments were then placed.

The patient was moved to the recovery area in satisfactory condition. All needle and sponge counts were correct.

Area	Fluid In	LSL Out	MLE Out	Total	Notes	Fibrotic(0-3)	Bleeding (0-3)	MLE (1-3)	LSL (1-3)
Abdomen	1600cc	900cc		Tissue excision weight = 1 lb					
Left Leg	750cc	500cc	75cc			3	0	3	2
Left Thigh	1300cc	500cc				3	0	3	2
Right Leg	580cc	400cc	50cc			3	0	3	2
Right Thigh	1160cc	200cc				3	0	3	2
Total	5390cc	2500cc							

POST OPERATIVE NOTE

DATE

9/14/22

SURGEON

Dr. Schwartz

ASSISTANT (S)

ANESTHESIOLOGIST

L. Johnson

ANESTHESIA

☒ General ☐ MAC ☐ IV Sedation ☐ Local ☐ Other: _____

PRE-OP DX

Lipedema/Dercums

POST-OP DX

PROCEDURE (S) PERFORMED

Lipedema Reduction surgery to posterior legs, thighs
+ Right Hip, Dercums Reduction surgery of abdomen
with possible direct excision, liposuction and skin excision.

EBL

☐ Minimal ☐ <20cc ☒ < 50cc ☐ < 100cc ☐ Other: _____

PATHOLOGY

☒ N/A ☐ Soft Tissue ☐ Bone

MATERIALS

☒ Vicryl ☐ Nylon ☐ Fast absorbing ☐ Silk ☐ Other: _____

INJECTABLES

_____ cc of _____

_____ cc of _____

IMPLANTS

☒ N/A ☐ _____

TUMESCENT SOLUTION (STRENGTH)

30mL 1% Lidocaine, 2 Epi, 60mL 0.2% Ropivacaine, 3mL TXA
3mL epinephrine

IN: 5398 cc OUT: 2500 LIQ: 100

IV FLUIDS

SEE ANESTHESIA RECORD

URINE OUTPUT

☒ Yes ☐ No ☐ N/A

COMPLICATIONS

☐ Yes ☒ No ☐ See Progress Notes

CONDITION

☒ Tolerated procedure well ☒ Vital Signs Stable ☒ Vascular Status intact to Op Site

COMMENTS

SIGNATURE:

J. C. RN

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

POST ANESTHESIA CARE ORDERS		RN Initials	Time Noted
OXYGEN			
<input checked="" type="checkbox"/> 3-10 liters per minute via facemask to maintain O2 saturation >95%	JL	1109	
<input type="checkbox"/> 2-4 liters per minute via nasal cannula to maintain O2 saturation >95%			
IV			
<input checked="" type="checkbox"/> Run current IV at: TKO	JL	1109	
<input checked="" type="checkbox"/> Saline lock IV	JL	1109	
<input type="checkbox"/> D/C prior to discharge			
Pain Management – ORAL (when tolerating liquids by mouth)			
<input checked="" type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Tylenol 500mg PO	JL	1109	
<input checked="" type="checkbox"/> Gabapentin 300mg PO	JL	1109	
<input checked="" type="checkbox"/> Gabapentin 600mg PO	JL	12:20 pm	
<input checked="" type="checkbox"/> Percocet (Oxycodone) 5/325mg PRN pain 5/10 X 1	JL	1130	
Pain Management – Intravenous			
<input type="checkbox"/> Toradol 30mg PRN pain OK NO TORADOL!!			
<input type="checkbox"/> Demerol 12.5mg PRN shivering			
<input type="checkbox"/> Dilaudid 0.2mg PRN pain may repeat Q 5 minutes, max dose 1mg, hold for RR <12			
Post-op Nausea and Vomiting			
<input checked="" type="checkbox"/> Zofran 4mg IV	JL	1109	
Additional Orders:			
<input checked="" type="checkbox"/> VO/RB&C (verbal order read back and confirmed)	JL	1109	
<input checked="" type="checkbox"/> May discharge patient when alert, vital signs stable, discharge criteria met AND evaluated by discharge practitioner	JL	1109	
Anesthesia Provider Signature	Date/Time	9.14.22	

Yang CRNA
L. Johnson

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
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KEENAN, CHRISTINE FEMALE
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NURSING / PROGRESS NOTES:

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
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KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON : JAIME SCHWARTZ, MD



What Medication Will I Take for Pain Postoperatively?

While we strive to ensure you have a serene journey through surgery, it is normal to experience some discomfort following your procedure. Our goal is to provide you with a comprehensive strategy to minimize any discomfort. With a focus on patient safety, we have elected to prescribe an antibiotic for prevention of infection. Below is a list of medications commonly prescribed for your surgery. **Please let us know if you have an allergy to any of these medications.** Please call 310-882-5454 with any questions

Post-operative appointment:

Date: 9/15/22 Time: @ 10am

****Please take a 600mg dose of Gabapentin BEFORE arrival for your post-operative visit**

STARTING THE EVENING OF YOUR SURGERY:

Acetaminophen 500mg (pain prevention) ***MAX dose in 24 hours is 4000mg**

Take 2 pills (1000mg)

START AT: 1:30 pm

RE-DOSE AT: 9:30 pm REPEAT EVERY 8 HOURS (rotate with Ibuprofen)

Ibuprofen 600mg (pain prevention) DO NOT TAKE IF YOU HAVE HAD **GASTRIC BYPASS** * MAX dose in 24 hours is 3600mg

Take 1 pills (600mg) by mouth every 8 hours (rotate with Acetaminophen)

START AT: 3:30 pm

RE-DOSE AT: _____ REPEAT EVERY 8 HOURS (rotate with Acetaminophen)

Gabapentin 300mg (pain prevention)

Take 1 pill (300mg) by mouth every 8 hours

START AT: 1:30 pm given in recovery 12:20 pm

RE-DOSE AT: 9:30 pm 9:20 pm

***May increase to 600mg for each dose if pain is persistent**

Acetaminophen and ibuprofen should be alternated. For example, you will take acetaminophen (1000mg) at 6pm and FOUR hours later at 10pm you will take ibuprofen (600mg) - then repeat each of them 8 hours after the initial dose. This will allow you to take pain prevention medication every 4 hours.

patient
NOT
taking!

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD



DAY 1 POST-OP:

Acetaminophen 500mg (pain prevention) *MAX dose in 24 hours is 4000mg*
Take 2 pills (1000mg) by mouth every 8 hours
Ibuprofen 600mg (pain prevention) DO NOT TAKE IF YOU HAVE HAD GASTRIC BYPASS
Take 1 pills (600mg) by mouth every 8 hours * MAX dose in 24 hours is 3600mg
Gabapentin 300mg (pain prevention)
Take 1 pill (300mg) by mouth every 8 hours *May increase to 600mg for each dose if pain is persistent Please take a 600mg dose of Gabapentin BEFORE arrival for your post-operative visit
Cefadroxil 500mg (antibiotics)
Take 1 pill (500mg) by mouth every 12 hours *make sure to take with food
Colace 100mg (stool softener)
Take 2 pills by mouth, three times a day *Discontinue after first bowel movement
Xarelto 10mg (clot prevention) - IF PRESCRIBED
Take one pill a day by mouth

DAY 2 - 7 POST-OP:

Acetaminophen 500mg (pain prevention)
Take 2 pills (1000mg) by mouth every 8 hours *MAX dose in 24 hours is 4000mg*
Gabapentin 300mg (pain prevention)
Take 1 pill (300mg) by mouth every 8 hours *May increase to 600mg for each dose if pain is persistent
Cefadroxil 500mg (antibiotics)
Take 1 pill (500mg) by mouth every 12 hours *make sure to take with food
Colace 100mg (stool softener)
Take 2 pills by mouth, three times a day *Discontinue after first bowel movement
Xarelto 10mg (clot prevention) - IF PRESCRIBED
Take one pill a day by mouth

TAKE BELOW MEDS IF NEEDED:

Oxycodone 5mg/Acetaminophen 325mg "5/325" (treatment of pain)
Take 1 pill (5/325mg) by mouth every 4-6 hours as needed *Reduce dose of Acetaminophen to 500mg if taking Oxycodone

* Given in Recovery 11:30 AM

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

DISCHARGE INSTRUCTIONS

Patient Name: _____ Post Op Phone #: _____

1. GENERAL ANESTHESIA OR LOCAL WITH SEDATION

- ☒ Do not drive or operate any mechanical tools or devices for 24 hours
- ☒ Do not consume alcohol or aspirin containing products for 24 hours
- ☒ Do not sign any legal documents or make any important personal or business decisions for 24 hours.

2. ACTIVITY

- ☒ You are advised to go directly home and restrict your activities and rest today.
- ☒ No strenuous activities, heavy lifting or exercise until directed otherwise
- ☐ You may shower/bathe in _____ hours.

3. FLUIDS AND DIET

- ☒ Begin with clear liquids and light foods and advance as tolerated.

4. PRESCRIPTIONS

- ☒ Use as directed and discussed with surgeon
- ☒ You may resume your daily prescription medication schedule as discussed
- ☒ Do not resume COUMADIN for _____ days, unless specifically instructed.
- ☒ Do not take aspirin unless specifically instructed.
- ☒ Take all pain medication with food.
- ☒ Finish all antibiotic prescriptions until empty or otherwise instructed.

5. OPERATIVE SITE

- ☒ Keep dressing clean and dry
- ☒ Do not remove dressings or garment until seen by your doctor or until directed.
- ☒ Signs of infection are redness, swelling, temperature, and unusual drainage. Call your surgeon if these occur.

6. FOLLOW UP CARE

- ☐ Your appointment is scheduled 9/15/22 @ 10am

7. SPECIAL INSTRUCTIONS

PLEASE CALL 310-882-5454 IF YOU HAVE ANY CONCERNS. If emergency call 911.

Signing below acknowledges that you have received these instructions and understood.

J. Candello, RN
Nurse Signature

[Signature]
Responsible Party Name/ Signature

9/14/22 1pm
Date/ Time

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

Physician's Admission Orders

For pick-up, call: (310) 879-2273. Please give us two hours notice.

Date: 09/14/2022

Surgeon's Name: Dr. Jaime Schwartz Office Tel #: _____

Cell Phone # _____ Alternate Tel #: _____

Next Appointment Date: 09/15 Time: 10 AM Expected No. Days Stay: _____

At facility ☐ At doctor's office ☐ At surgery center ☒

Patient's Name: Christine Keenan Age: 57 DOB: 02/21/1965

Patient's Emergency contact: Randy Phone: 917-320-1934

A copy of Patient's pre-operative history and physical exam must be attached to this form.

Food Allergies: _____

Medication Allergies: Morphine

Pertinent Medical History: Hypertension, Asthma, cholecystectomy, kidney disease

Patient's Routine Medication (pre-existing medical conditions) to be continued, including dosage:

- | | |
|--|----------------------|
| 1. see med list <u>Omeprazole</u> | 3. <u>Gabapentin</u> |
| 2. <u>Hydrochlorothiazide</u> | 4. <u>Vitamin D</u> |

Procedures:

- | | |
|--|--|
| 1. <u>Liposuction reduction surgery Posterior legs, Thighs, R Thighs</u> | 3. <u>Liposuction reduction surgery of Abdomen</u> |
| 2. _____ | 4. <u>possible direct excision, liposuction, skin excision</u> |

Type of Anesthesia: General ☒ I.V. (M.A.C.) ☒ Local: _____

Length of Procedure: 3.5 Length of Recovery: 1.5 (1 1/2 hr min)

Number of Drains: 4 Location: Lower legs / Abdomen Drainage Recorded in Recovery _____

Medication Given in Recovery: Percocet Time: 1130

Gabapentin 400 mg Time: 1210

Time: _____

Current Vital Signs: T 97.6 BP 120/69 P 65 R 16 SPO2 99

Discharge Evaluation:

	YES	NO
Alert & well oriented	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Able to ambulate	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Taking fluids p.o.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Absence of nausea	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Voiding without problem	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Free of acute pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dressing intact	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Foley Catheter	<input type="checkbox"/>	<input checked="" type="checkbox"/>
IV Line	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Post-Operative orders: A copy of the patient's post-operative and follow-up care instructions must be attached to this form.

Cold Compresses to: Eyes ☐ Face ☐ Neck ☐ Other _____ For 24 hrs ☐ 48 hrs ☐ PRN ☐ after admission.

Continuous (20 min on / 20 min off) ☐ Q 1hr (20min on / 40min off) ☐ Other _____

Ice Mask ☐ Ice Pack ☐ 4x4 ☐ Peas ☐ Glove ☐ Interrupt Sleep: Yes ☐ No ☐

Laser Skin Care: Clean Skin: Yes ☐ No ☐ with _____ every _____ hrs.

Vinegar Soak: _____ Tbs with _____ cup(s) water starting _____ TID ☐ QID ☐ Other _____

Ointment: Yes ☐ No ☐ Type _____ Applied to: _____ every _____

Suture Line Care: Clean with: H2O ☐ H2O2 ☐ Other: _____ every _____ hrs.

Ointment: _____ Applied to: _____ every _____ hrs.

Eye Care: Drops Type _____ Applied to: Both ☐ Right ☐ Left ☐ every _____ PRN _____

Ointment Type _____ Applied to: Both ☐ Right ☐ Left ☐ every _____ PRN _____

Oral Care: Rinse with H2O ☐ H2O2 ☐ Other _____ every _____ PRN _____

Homeopathics: Type _____ Applied to: _____ every _____ PRN _____

Type _____ Applied to: _____ every _____ PRN _____

IV Care: Desired Maintenance Fluid _____ OK to D/C on _____

Drains To Be Emptied: PRN/Q12 ☐ Other _____ D/C Foley on _____

Wound Assessment: Do ☐ Do Not ☒ Remove Dressing/Garment to Assess Wound QD ☐ Other _____

Ambulation: Starting on admission QD ☐ BID ☐ TID ☐ With Assistance ☐

Oxygen: _____ liters per minute via nasal canula ☐ mask ☐ for _____ hrs Incentive spirometer every _____ hrs.

Diet: Clear liquids only ☐ Full Liquids ☐ Soft diet ☐ Regular diet ☐ Advance as tolerated ☒ Restrictions: _____

Other Treatment Instructions:

SCD ☐ Bed Rest ☐ Assistance to bathroom ☒ Semi-fowler position ☐ Knees flexed ☐ Neck Roll ☐

No pillow behind head ☐ Remove TED Hose on _____ Remove head/other dressing on _____

Shampoo hair carefully on _____ OK to shower on _____

Prescription Medications and Dose (attach additional sheet if needed):

1. see med list
2. _____
3. _____
4. _____
5. _____
6. _____

Homeopathic Medicines (including all complete directions):

1. _____
2. _____
3. _____
4. _____

All above listed prescriptions are: in patient's possession ☒ verified by Prestige staff (name) Andrew

Ordered from _____

Discharge Order: OK to discharge patient on (date): _____ if no medical complications are present.

Signature of Attending Physician/Surgeon: _____ **Date:** 09/14/2022

KEENAN, CHRISTINE FEMALE
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Post-Operative Follow-Up Phone Call

Patient Name: _____ Telephone Number: _____

Operation: _____ Date of Operation: _____

Times Called: ____ 1 ____ 2 ____ 3 Date of Contact: _____

Time Called: _____

1. Check one of the following:

- ☐ The patient is feeling well
- ☒ The patient is having pain, however pain medication is adequate.
- ☐ The patient is having pain, but pain medication is not adequate.
- ☐ _____

2. Check any of the following that apply to the patient:

- ☐ Drainage or bleeding from the incision, not WNL
- ☐ Nausea or vomiting
- ☐ Fever, chills or sweating
- ☐ Sore throat, hoarseness, cough
- ☐ Tingling, numbness, swelling of fingers/ toes
- ☐ Reaction from medication or anesthesia
- ☐ _____
- ☒ None of the above apply
- ☐ Problem addressed and resolved by nurse over the phone
- ☐ Patient advised to be seen at the doctors office

3. Answer Yes or NO to each of the following:

- ☒ Was the patient given written post-operative instructions? YES
- ☒ Does the patient understand the post-operative instructions? YES
- ☒ Does the patient have a follow-up appointment? YES

4. Comments: IN OFFICE 9/15

Signature : _____

TLC Surgical Center
240 S. La Cienega, Suite 210
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KEENAN, CHRISTINE FEMALE
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TLC Surgical Center
240 S La Cienega Blvd, Suite 210
Beverly Hills, Ca 90211
(310) 882-5454

Acknowledgement of Legal Relationship Between the Surgery Center & Physicians

All Physicians and surgeons furnish services to the patient, including the anesthesiologist, and other surgical center based physicians and the like are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the surgery center and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's consent or informed consent, when required, to medical or surgical treatments, special diagnostic or therapeutic procedures, or surgery center services rendered to the patient under general and special instructions of the physician. The Surgery Center based physicians fees (Surgeon and Anesthesiologist if applicable to your case) are billed separately and independently of surgery center charges, which means you will receive multiple bills for your procedure.

I hereby acknowledge and understand the legal relationship between The TLC Surgical Center and the physicians.

Christine Keenan Chlepon 9/13/22

Patients Name

Patients Signature

Date

J. Caudillo Lea Caudillo 9/14/22

Witness Name

Witness Signature

Date

KEENAN, CHRISTINE FEMALE
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(310) 882-5454

Notice to Patients in the Event of Needing Emergency Care

These directives pertain to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on their own behalf. Advanced directives generally fall into three categories: living will, power of attorney and health care proxy.

Living Will: A written document that specifies types of medical treatment desired. A living will can be very specific or general.

Health Care Proxy: A legal document in which an individual designates another person to make health care decisions if he or she is rendered incapable of making their wishes known.

Durable Power of Attorney: This is the third type of advance directive. Individuals may draft legal documents providing power of attorney to others in the case of incapacitating medical conditions.

The TLC Surgical Center will respect any Advance Directive that may be in place. However, the Center will NOT implement the request. If you bring a copy of an advance directive or living will, a copy will be made and placed in your medical record. Should the need for a transfer to a hospital occur, this copy will be forwarded to the hospital of transfer and they may honor these directives.

The law does not require that patients have or make an advanced directive. **Please check the appropriate box below.**

☒ Yes, I have provided the Center with a copy of my Advance Directive/ Living Will. The Center has explained to me their policy regarding the implementation of this document and I agree to proceed with the proposed procedures as scheduled.

☐ I do not have an Advance Directive/Living Will. I request the facility provide me with information about Advanced Directives. I understand that TLC Surgical Center will not implement an Advance Directives, but will transfer this document with me should the need arise.

☐ I DO NOT have an Advance Directive/Living Will. I DO NOT want information.

X *[Signature]*
Patient Signature

9/13/22
Date

[Signature]
Witness Name

lea Caudillo
Witness Signature

9/14/22
Date

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

LIST OF PATIENTS RIGHTS

1. Patients are treated with respect, consideration, dignity and are provided appropriate personal privacy.
2. Patients have the right to receive adequate notice regarding this facility's privacy practices. Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse the release, except when release is required by law.
3. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
4. When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.
5. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
6. Patients have the right to the facility's rules and regulations as they apply to their conduct, responsibilities and participation as the patient.
7. The patient has the right to change their provider if other qualified providers are available.
8. Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care, and related fees for services rendered.
9. Be informed of charges, fees for service, payment policies, receive an explanation of your bill and receive counseling on the availability of known financial resources for health care services.
10. Be informed of your right to refuse to participate in experimental research if applicable.
11. Know that, in the event that a patient has an advance directive, it is the policy of the facility to resuscitate all patients; however, any advance directive will be noted in the patients medical record and will be communicated to other medical facilities, if a transfer is needed.
12. The patient has the right to receive enough information from the physician so that he/she can understand the services being rendered in order to sign the informed consent.
13. The patient may leave this facility, even against the advice of his or her physicians.
14. Reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
15. Be free from all forms of abuse, discrimination, harassment or reprisal. Receives access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion, or sources of payment for care.
16. Know that your physician may have financial interest or ownership in the facility.
17. Know the name and role of your caregiver (e.g., doctor, nurse, technician, etc). You have a right to request information, malpractice insurance coverage and/or credentials about the physician providing your care.
18. Report any comments or voice any grievances concerning the quality of services provided to the patient during the time spent at the facility without being subjected to discrimination or reprisal and receive timely, fair follow-up on your comments.
19. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

For complaints or comments about your medical care, you may call or contact:

- TLC Surgical Center, 240 S. La Cienega Suite 210 Beverly Hills, Ca 90211 (424)452-1054
- The Medical Board of California-2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 (916) 263-2382, fax (916) 263-2944
- AAAASF - 7500 Grand Ave Suite 200, Gurnee, IL 60031. (888)545-5222

Christine Keenan

Patient Name

[Signature]

Signature

9/13/22

Date

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
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(310) 882-5454

PATENT RESPONSIBILITIES

AS A PATIENT IN OUR FACILITY, YOU HAVE CERTAIN RESPONSIBILITIES, WHICH INCLUDE:

1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. Follow the treatment plan prescribed by his/her provider.
3. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours.
4. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
5. Accept personal financial responsibility for any charges not covered by his/her insurance.
6. Be respectful of all the health care providers and staff, as well as other patients.
7. Respect the privacy of other patients.
8. To work with your health care team and to follow all safety rules.
9. To tell your doctor about any changes in your health after you leave our facility.
10. To keep, or cancel in a timely manner, your scheduled appointments for your health care.
11. To tell your health care team if you wish to change any of your decisions.
12. To ask for clarification if you do not understand any information or instructions given to you by your health care team.

IF YOU HAVE CONCERNS:

If you have any questions or concerns about your responsibilities, you can contact our administrator or if you wish to file a complaint about your care in our facility please refer to your Patients Rights for addresses and telephone numbers.

Christine Keenan Christine Keenan 9/13/22
Patients Name Patients Signature Date

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

PRIVACY ACKNOWLEDGEMENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment, health care operation and peer review of charts.


As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have to indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment in health care operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to reuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objection to this form, please ask to speak with our HIPPA Compliance officer.

You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Print Name: Christine Keenan Signature:  Date: 9/13/22

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310-882-5454

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rate share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by patient.

Article 6: Severability Provision: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: TLC SURGICAL CENTER
240 S. La Cienega, SUITE 210
BEVERLY HILLS, CA 90211

By:

Patient Signature

Date

Christine Keenan

Print Patient Name

Date

TLC Surgical Center
240 S. La Cienega, Suite 210
Beverly Hills, Ca 90211
310-882-5454

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
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TOTAL LIPEDEMA CARE

Consent for High Volume Liposuction in Lipedema

- My doctor has explained to me that the traditional limit of liposuction aspirate volume is 5 Liters of fluid and tissue removed. It has been explained to me that in accordance with consensus guidelines in the treatment of lipedema it is occasionally possible to safely remove more than 5 liters of aspirate. The disease lipedema is a unique setting in which higher volumes of aspirate can frequently be safely removed. The potential advantage of higher volume liposuction is that lipedema may be treated in fewer surgical procedures with more rapid relief of symptoms.
- Despite the relative safety, I understand that higher volumes of aspirate do potentially increase the chances of surgical complications. These include, but are not limited to, seroma, dehydration, dizziness, bleeding, bruising, pain, nerve damage and falling. By agreeing to higher volume liposuction, I understand I may require a blood transfusion to treat anemia (although that is rare.)
- By agreeing to high volume liposuction, I understand I will need to maintain excellent oral hydration after the surgery to minimize risks. It is not uncommon to require iv hydration after this surgery to optimize fluid levels. Our recommendation is to have medical monitoring overnight at a recovery facility or with a medical provider such as a nurse. This will be your financial responsibility but your safety is paramount.
- There is no guarantee or promise as to the amount of liposuction aspirate that will be removed. That is left entirely to the intra-operative discretion of my surgeon. My surgeon is granted full final authority to determine the liposuction volume that they deem to be safe for me.

Initial

Ch

I understand the information presented above including the risks and benefits of high volume liposuction.

I Do request high volume liposuction

Signature

Christine Keenan

Date

9/13/22

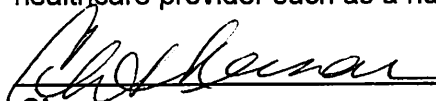
KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

I Decline high volume liposuction_____

Signature

Date

I agree to be monitored for at least the first evening at a recovery facility or with a licensed healthcare provider such as a nurse as is recommended by my physician


Signature

9/13/22
Date

I decline to be monitored for at least the first evening at a recovery facility or with a licensed healthcare provider such as a nurse as is recommended by my physician

Signature

Date

KEENAN, CHRISTINE FEMALE
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SURGEON : JAIME SCHWARTZ, MD

**AXIOM ANESTHESIA
FINANCIAL AGREEMENT / CREDIT CARD AUTHORIZATION**

Medicare. I request that payment of authorized Medicare benefits be made on my behalf to Axiom Anesthesia and/or its authorized agents for services furnished to me by Axiom Anesthesia and/or its authorized agents. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature below authorizes that payment be made to Axiom Anesthesia and/or its authorized agents and authorizes release of medical information necessary to support a claim for payment. If a secondary insurance is listed, my signature authorizes releasing information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Axiom Anesthesia and/or its authorized agents, otherwise to me. I am responsible only for the deductible, coinsurance, and non-covered services, which are based upon the charge determination of the Medicare carrier.

Release of Information. Axiom Anesthesia and/or its authorized agents may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation which is or may be liable under contract to Axiom Anesthesia and/or its authorized agents for reimbursement for services rendered.

Out of Network Provider. I understand that Axiom Anesthesia has no contract, express or implied with any insurance company or health plan (except Medicare). I understand and agree to use my out-of-network insurance benefits for billing the costs of anesthesia services. I understand and agree that all co-payments and deductibles are due at the time the anesthesia services are provided and will be collected at that time. If my insurance company sends reimbursement checks to me for anesthesia services, I must endorse the check and forward to Axiom Anesthesia with the Explanation of Benefits (EOB) within five (5) days of check receipt. If I deposit this check, I am financially responsible for the fees and associated costs.

Non-Covered Services. I accept full financial responsibility for all items or services, which are determined by the insurance company or health plan to be "non-covered services." Examples of "non-covered" services include services determined by the insurance company or health plan to be experimental, services not specified as being covered in the insurance company or health plan documents or benefit summary, or services not authorized by the insurance company or health plan.

Assignment of Benefits and Financial Agreement. I understand that I may consult with the anesthesia provider prior to the anesthesia regarding my financial obligations. In signing this form, I understand and agree that in return for the services provided to me by Axiom Anesthesia and/or its authorized agents I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Axiom Anesthesia and/or its authorized agents. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I assign to Axiom Anesthesia and/or its authorized agents any benefit of any insurance policy that provides coverage to me. I agree to pay co-payments, co-insurance and/or deductibles that are designated by my insurance company or health plan. In signing this form, I understand that I am primarily responsible for the payment of my bill.

KEENAN, CHRISTINE FEMALE
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Credit Card Authorization. I authorize Axiom Anesthesia and/or its authorized agents to charge the credit or debit card indicated below. Upon request, I will be provided a receipt for any charges or debits made. I understand and agree that this authorization will remain in full force and effect until certification that Axiom Anesthesia and/or its authorized agents have received written notification from me of cancellation and Axiom Anesthesia and/or its authorized agents have had a reasonable opportunity to act upon it. Axiom Anesthesia may save the information to my file for future transactions on my account.

Initial one option:

 Initial: I elect to forego my insurance benefits and pay an upfront cash rate of \$400 for the first hour of surgery and \$200 for each subsequent hour.

CP **Initial:** Please submit the anesthesia services claims to my insurance and Axiom Anesthesia may charge my credit for the portion my insurance deems I am financially responsible.

Credit or Debit Card Information	
Cardholder Name: <u>Christine Keenan</u>	
Card #: <u>5189 410044144270</u>	Security Code #: <u>192</u>
Expiration Date: <u>05/25</u>	
E-Mail Address for Receipt: <u>Christine Keenan 76118@gmail.com</u>	

I certify that I have read the above information, I have had opportunities to ask questions and receive answers from Axiom Anesthesia and/or its authorized agents and I voluntarily and knowingly agree to be bound by the terms set forth above.

Patient Name: Christine Keenan

Patient Signature: [Signature] Date: 9/13/22

If someone other than the patient is signing this form, indicate name, title and authority to sign.

_____ Name of Authorized Person	_____ Title/Relationship to Patient
------------------------------------	--

I agree to provide a written copy of my Authority to Sign, to be stored together with this form.

KEENAN, CHRISTINE FEMALE
DOB: 02/21/1965 DOS: 09/14/2022
PHONE: (817)773-0435 MR#: 8252
SURGEON: JAIME SCHWARTZ, MD

Keenan, Christine (#8252)

DOB: 02/21/1965

Mobile Phone: (817) 773-0435	Chart ID:	Address: 9310 Mineral Rock Lane
Home Phone: (817) 773-0435	Language:	City: Richmond
Work Phone:	Interpreter Needed: No	State: TX
E-mail Address: christinekeenan76118@gmail.com	Occupation:	Zip: 77407
E-mail Allowed: Yes	Employer: NA	Insurance Company: Humana
SMS Allowed: Yes	Employer Address:	Insurance Policy #: H45578033
Marital Status: Married	Employer City:	Name of Insured: Christine Keenan
Spouse Name: Randy Keenan	Employer State:	Birth Date of Insured: 02/21/1965
Spouse Employer: Harris County	Employer Zip:	Employer of Insured: NA

Emergency Contacts

Name: 8173201934	Name: 2392231796	Name:	Name:
Phone #: Randy Keenan	Phone #: Patricia May	Phone #:	Phone #:
Physician: Dr. Amber Kazi	Physician:	Physician:	Physician:
Address: 17228 W. Grand Pkwy #2010	Address:	Address:	Address:
City: Sugarland	City:	City:	City:
State: TX	State:	State:	State:
Zip: 77479	Zip:	Zip:	Zip:
Phone: 832-841-4001	Phone:	Phone:	Phone:

Tags

Platinum Level Patient

1 day post op : 9/15/22 @ 10am
Friday Appt. : 9/16/22 @ 10am

Texas

USA
TX

DRIVER LICENSE



4d DL 22560744 9 Class C
4a Iss 04/05/2017 4b Exp 02/21/2023
3 DOB 02/21/1965
1 KEENAN
2 CHRISTINE T
8 9310 MINERAL ROCK LANE
RICHMOND TX 77407
12 Restrictions A 9a End NONE
16 Hgt 5'-07" 15 Sex F 18 Eyes HAZ
5 DD 08213710144005877281



Christine T. Keenan

Humana

HUMANACHOICE (PPO)

A Medicare Health Plan with Prescription Drug Coverage

Dental Included

CARD ISSUED: 11/19/2020

CHRISTINE T KEENAN

Member ID: H45578033

Plan (80840) 9140461101

RxBIN: 015581

RxPCN: 03200000

RxGRP: Y9535

Copayments

OFFICE VISIT: \$5

SPECIALIST: \$35

HOSPITAL EMERGENCY: \$90

MedicareRx
Prescription Drug Coverage

CMS H5216 043



Member/Provider Service: 1-800-457-4708

If you use a TTY, call 711

Pharmacist/Physician Rx Inquiries: 1-800-865-8715

Claims, PO Box 14601, Lexington, KY 40512-4601

Medicare limiting charges apply

Please visit us at **Humana.com** (For Dentists - **Humana.com/sb**)

Additional Benefits: DEN978 VIS751 HER941

EyeMed Vision: 1-888-289-0595

