NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

Department of Perioperative Services

Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: ____________________

Fluent in English: ☐ Yes ☐ No Preferred Language Spoken: ____________ Translator needed: ☐ Yes ☐ No

Age: ________ Sex: ________ Date of Birth: ____/____/____

Surgeon Name: ____________________ Expected Date of Surgery ____/____/____

Primary Care Physician: ____________________

Primary Care Physician's Phone No. (______) ____________

Cardiologists Name ____________________ Phone No.: (______) ____________

Expected Procedure: ____________________

Home Phone: (______) ____________ Work Phone: (______) ____________ Cell Phone: (______) ____________

Telephone Number to be Reached Prior to Surgery: ____________________

Best time to call: ☐ Afternoon ☐ Evening May we leave a message? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER ____________

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

What previous Anesthesia have you had?

☐ General ☐ Regional ☐ Spinal ☐ Epidural ☐ Local ☐ None ☐ Unsure

Please list any complications/problems experienced with anesthesia.

____

____

____

Please list prior Hospitalizations including Emergency Department visits

____

____

____

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Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

	PATIENT ONLY		CLINICIAN USE ONLY	
Heart: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
1) Atrial fibrillation or irregular heartbeat?			EKG	*
2) High blood pressure or Mitral Valve Prolapse?			EKG	
3) A heart attack, angina, or chest pain?			CBC, EKG	*
4) A heart murmur, heart failure or heart surgery?			CBC, EKG	*
5) High cholesterol?				
6) Chest pain or shortness of breath when climbing a flight of stairs?			EKG	*
7) A catheterization of your heart? If so, ... Date ___/___/___ Where ______			CBC, EKG	*
8) A heart stress test? If so, ... Date ___/___/___ Where ______			CBC, EKG	
Do you: 9) Take antibiotics prior to a surgical procedure or dental work?				
10) Do you have a pacemaker or implantable defibrillator (AICD)? If yes, manufacturer: (check one) ☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Biotronik ☐ Other. Date ___/___/___ Where ______ *Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.*			**If yes, contact EP specialist**	
11) Are you 60 years old or older?			EKG	

Breathing: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
12) Shortness of breath with exertion or swollen ankles?			CBC, EKG	*
13) A need for more than one pillow or wake up at night short of breath?			CBC, EKG	
14) Tuberculosis (TB)?			CXR	
15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?			CBC, CXR	
16) Smoked in the last year?				
17) Oxygen at home to help you breathe?			CBC, CXR	*
18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?			EKG, CXR	*
19) Did you ever have an embolus or clot go to your lung?				

Obstructive Sleep Apnea (OSA):	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
20) Do you have Obstructive Sleep Apnea (OSA)?			CBC, EKG, CXR	*
21) Do you frequently snore loudly, enough to be heard through closed doors?			CBC, EKG	
22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?			CBC, EKG	*
23) Do you have or are you being treated for high blood pressure?			EKG	
24) Do you use a BIPAP or C-PAP machine at home? If so, settings: ______			CBC, CXR	*

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

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Department of Perioperative Services

Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

	PATIENT ONLY		CLINICIAN USE ONLY	
Blood Disorders: Do you have or ever had the following:	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
25) Anemia or low blood count?			CBC	
26) Bleeding ulcers or rectal bleeding?			CBC	
27) Sickle cell disease or trait?			CBC, CXR	
28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?				
Do you: 29) Use warfarin (Coumadin) as a blood thinner?			PT/INR	*
30) Bruise easily and/or have a bleeding problem?			CBC, PT/INR/APTT	
Endocrine/Renal Disorders: Do you have or ever had the following:				
31) Diabetes?			BMP, EKG	
32) Adrenal or thyroid disease or tumor?			BMP	
33) Kidney disease, kidney failure or are you on dialysis?			BMP, EKG, CBC	
34) Severe hepatitis, jaundice, cirrhosis or liver failure?			LIV, PT, INR, APPT	
35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?			BMP, EKG	
Gastrointestinal: Do you have or ever had the following:				
36) Severe abdominal pain?				
37) Loss of appetite or unintentional weight loss in the past year?				
38) Acid reflux?				
Neurological/Musculo/Skeletal: Do you have or ever had the following:				
39) Stroke or seizures?			BMP, EKG, CBC	
40) Weakness in your arms or legs?				
41) Head, neck or back injuries?				
42) Chronic pain?				
43) "Pins and needles" or loss of sensation in your arms or legs?				
44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?				
Obstetrics				
45) Are you or do you believe you might be pregnant?			BHCG	
Last menstrual cycle ______				
46) Have you been pregnant in the last 3 months?			If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	
Cancer: Do you have or ever had the following:				
47) Cancer and/or received chemotherapy?			CBC	
48) Have you received radiation therapy?			CXR, EKG, CBC	
49) An axillary lymph node dissection (under arm): ☐ Yes ☐ No				
Which side: ______				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

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Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Anesthesia Related Issues: Have you had:	PATIENT ONLY		CLINICIAN USE ONLY	
	No	Yes	Test for "Yes" Answers	Anesthesia Consult *
50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?				*
51) Surgery on your throat, vocal cords or lungs?				*
52) Any bad reactions to anesthesia in you or your relatives?				*
53) A history of Malignant Hyperthermia in you or any of your relatives?				*
54) Do you have trouble opening your mouth or bending your neck forward or backward?				*
55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?				*
*You will see **YOUR** anesthesiologist on the day of surgery. In addition,* 56) Do you want to see a screening Anesthesiologist before the day of Surgery?				*

Communicable Disease: Do you have or ever had the following:

	No	Yes		
57) ☐ HERPES ☐ AIDS ☐ HIV				
58) Contact within the last month with anyone suspected of having SARS?				
59) Have you traveled outside of the U.S. in the last month? If yes, where? ____________				

Eyes: Do you have or had the following:

	No	Yes		
60) Dry eyes?				
61) Glaucoma or cataracts?				

Behavioral Health

	No	Yes		
62) Have you suffered from anxiety, depression, or a psychiatric disorder?				

Blood Transfusion: Do you have or had the following:

	No	Yes		
63) Blood transfusion in the last 3 months?			If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	
64) A reaction or allergy to a blood transfusion?				
65) Did you donate blood for this surgery?				
66) Did a family member donate blood?				

* Anesthesia Consult Recommended
CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB. ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature ______________________ Date: ___/___/_____ Time: ________ AM/PM

If completed by the RN: ______________________ RN Date: ___/___/_____ Time: ________ AM/PM
Nurses Signature

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

46171

PRE-OP TESTING DOCTOR'S ORDERS / ADULTS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME	AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME
Intravenous fluids (for fluid replacement) Other large volume parenterals / Irrigations All controlled substances (including epidural infusions and patient controlled analgesia)	7 days	All medications (including intravenous and oral antibiotics) Warfarin	30 days 24 hours for the first 7 days, after that orders will be valid for 7 days if the patient is within therapeutic range

LEGIBILITY and COMPLETENESS of medication orders counts - Please follow these Guidelines:

- Write out "units"
- Use leading zero, eg. 0.1 mg
- Write out "days" or "doses"
- Write out "microgram"
- Omit trailing zero, eg. 1 mg
- Print medication order
- Print name and ID code
- Sign all orders
- Add beeper number

DATE	TIME	DOCTOR'S ORDERS AND DOCTOR'S SIGNATURE	ORDER POSTED BY WHOM DATE, TIME	ORDER CHECKED BY RN DATE, TIME	ORDER FAXED DATE, TIME
		ALLERGIC/SENSITIVE TO:			
		Pre-op Testing Order(s)			
		☐ Lab / Test per Pre-op Medical Questionnaire (50705)			
		☐ Other Lab / Test			
		☐ Type & Cross per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyp.org/Lab/Transfusio/Index.asp			
		☐ Type & Screen per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyp.org/Lab/Transfusio/Index.asp			
		Provider Signature: ______________________ MD, PA, NP Print Name/I.D. Code: ______________________ Date: ____/____/______ Time: __________ AM/PM			

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

51167

HOME MEDICATION LIST: AMBULATORY

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

Date: ______/______/______

Information Source: ☐ Patient ☐ Spouse ☐ Family member/Other ____________ ☐ Medications brought from home

List only medications patient is currently taking at time of visit.

Allergies: ☐ None ☐ Latex ☐ Other

[illegible]

☐ Patient does not report taking any medications at home. ☐ Patient/Family unable to provide medication information.

Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

New Medications

Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

Stop Taking STOP

Medication Name/Strength	Dose	How (Route)	When (Frequency)	Why (Indication)	Comments/Special Instructions

Form completed by: ____________________ ____________________

Print Name Circle Appropriate (MD / RN / PA / NP / RPH) Print Name Circle Appropriate (MD / RN / PA / NP / RPH)

51167 ACN (8/07)

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The University Hospitals of Columbia and Cornell

Joan and Sanford I. Weill Medical College

PETER N. SCHLEGEL, M.D., F.A.C.S.
Chairman, Department of Urology
Urologist-in-Chief

Department of Urology
Brady Urologic Health Center
525 East 68th Street
New York, NY 10021

Tel: 212-746-5491
Fax: 212-746-8425
pnschleg@med.cornell.edu

EPIDIDYMAL SPERM RETRIEVAL

To clarify the source of sperm to be used for IVF-ICSI in your upcoming cycle, I ask you to complete the following preference list that outlines which sperm source to use for your upcoming cycle:

YES ☐ NO ☐ I have epididymal or testicular sperm frozen.
Where is it being stored? ____________________

Order of preferences (please number) cross out any that does not apply.

☐ 1. Use Frozen – thawed epididymal sperm that are alive.

☐ 2. Use freshly retrieved live epididymal sperm.

☐ 3. Use freshly retrieved testicular sperm (usually only if no epididymal sperm available)

☐ 4. Please freeze any remaining epididymal or testicular sperm for possible later use. YES NO

We would like to follow the plan outline above ,but give our permission for the Embryology Laboratory to use its best judgement to amend the plan as needed.

Comments____
____
____

Patient's Name (Print)______________________Spouse Name (Print)__________

Signature______________________________

Date______________

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

The Ronald O. Perelman & Claudia Cohen
Center for Reproductive Medicine

Andrology Laboratory
1305 York Avenue, Y725, New York, NY 10021
Phone: (646) 962-8448 Fax: (646) 962-0347

CONSENT TO STORE AND USE HUSBAND'S SPECIMEN (IN-HOUSE)

I, ______________________ (male name) __________ (IDX #), am patient of the Center for Reproductive Medicine (CRM) at Weill Cornell Medical College, agree to provide a semen sample to the Andrology Laboratory for analysis, cryopreservation, and storage. The CRM Andrology Laboratory agrees to maintain and store my semen **sample for one year** from the date hereof. This agreement is not a guarantee of quality or viability. I also understand and agree to pay a **$150 quarterly storage fee**.

I understand that by signing this section I am giving permission to CRM Andrology Laboratory to release my semen sample to my spouse, designated below, for use in artificial insemination, *in vitro* fertilization or intracytoplasmic sperm injection.

______________________ ______________________
Female Partner's Name (print) Social Security Number (Female)

______________________ ______________________
Patient's Signature (Male Partner) Date

I understand that there are inherent risks in the process of storing semen, including, but not limited to, damage to the sperm, reduced capacity of fertilization, and reduced life span after thawing. At this time, there is no proven evidence that the cryopreservation of human spermatozoa increase chances of abnormalities in intrauterine development and birth defects versus the use of fresh semen. While it is also possible that the resulting child or children may be born with birth defects or possess otherwise undesirable traits or hereditary tendencies, or other problems or disabilities, such occurrence will generally be no more frequent or severe than in children conceived by fresh sperm.

Upon my demise my samples should be:
[ ] given to my spouse/partner [ ] donated for research purposes [ ] destroyed.

I also understand that there are potential risks involved with storing my semen at the Andrology Laboratory. Although semen samples are kept in liquid nitrogen in containers equipped with a temperature alarm system, accidental thaw damage or loss of sample, may occur at any time due to technical malfunction, the complete or partial destruction of the laboratory, or a variety of other reasons. I understand that I will only be entitled to damages equal to the storage fee in the event of such occurrence.

I also understand that if a culture reveals the presence of bacteria in my sample, I will be notified by my physician for eventual treatment and planning for another sample production.

Agreed and accepted:

______________________ ______________________
Patient's Signature (Male partner with copy of photo ID) Social Security Number (Male)

__________ __________ __________
Date Home Number Work Number

____
Address

__________ __________ __________ __________
Consent expiration Witness (Notary Public/Andrology) Notary Seal Date

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Peter N. Schlegel, M.D., F.A.C.S.
Professor and Chairman
Department of Urology
Urologist-in-Chief
Brady Urologic Health Center
525 East 68th Street
New York, NY 10065

Telephone: 212-746-5491
Fax: 212-746-8425
E-mail: pnschleg@med.cornell.edu

I (Patient's Name),________________________________,understand that on day of my scheduled surgical sperm retrieval, the decision of whether or not surgery will take place will be determined by Dr.Peter Schlegel. The following factors are involved in the decision making: semen analysis, evaluation of frozen samples if available, processing of the semen specimen, medical consultation with laboratory and other healthcare personnel.

For this medical decision making and evaluation of the medical value of the sperm specimen **a standby fee of $1500.00 must be paid if surgery is deemed not to be needed. If frozen samples are evaluated there will be an additional fee of $1000.00 for the laboratory processing of these samples.**

Agreed and accepted:

____________________ ____________________

Patient's Signature Date

MEDICATIONS TO AVOID BEFORE SURGERY

The following drugs contain aspirin or other products, which can cause increased bleeding during surgery and should not be taken for 10 days prior to surgery. If you should need to take something for relief of minor pain, you may take Tylenol.

Advil
Aleve
Alka Seltzer
Alcohol
Anacin
Anaprox
Ansaid
Arthrotec
Aspirin
APC
BC Tablets or Powder
BC Cold Powder
Brufen
Bufferin
Cama Arthritis Pain
Reliever
Cataflam
Celebrex
Cephalgesics
Clinoril
Cogesprin
Coricidin
Coumadin
Darvon
Darvon with Aspirin
Daypro
Diclofenac
Diflunisal
Disalcid Tablets or
Capsules
Doan's Regular and
Extra Strength
Dolobid
Dristan
Duradyne Tablets
Easprin
Ecotrin
Empirin
Enbrel
Equagesic Tablets
Etodolac
Excedrin
Feldene
Fiorinal
Flurbiprofen Sodium
4 Way Cold Tablets
Goody's Headache
Powder or Tablets
Ibuprofen
Indomethacin
Indocin
Ketoprofen
Lodine
Meclomen
Medipren
Meloxicam
Midol 200
Midol PMS caplets
Mobic
Motrin
Nabumeton
Naprelan
Naprosyn
Naprosyn Pepto Bismal
Tablets and Liquid
Naproxen
Norgesic forte
Orudis
Oruvail
Oxaprozin
Percodan
Persantine
Piroxicam
Plavix (Warfarin)
Quagesic
Relafen
Robaxisal
Rufen
Sine Aid
Soma Compound
Sulindac
Trandate
Trental
Trilisate
Vanquish
Vitamin E
Voltaren
Wesprin
Zavtrin
Zoprin
Herbal Supplements

Before stopping any of these medications, be sure to consult the physician who ordered them. Some, such as Coumadin (Warfarin) and Plavix, are ordered to prevent or treat serious conditions such as "deep venous thrombosis", "pulmonary embolisms", and other heart problems. This is not an all inclusive list. If you are unsure if you are taking an aspirin product or an anti-inflammatory, please ask your doctor, nurse or pharmacist.

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Microsurgical TESE

Testicular Sperm Extraction

Your biopsy will involve removal of a small amount of testicular tissue, from one or both testes, for examination under the microscope. The biopsy is performed in an attempt to retrieve sperm that can be injected into your wife's eggs, which are obtained during IVF treatment.

Pre-operative Preparation:

-You should be in the best of health.

-Avoid aspirin and aspirin like derivatives 1 week prior to surgery. Please see attached list.

-A pre-operative evaluation must be scheduled with our office. This visit should be within 1 month of surgery.

-We will typically give you Celebrex, an anti-inflammatory medication, to take before and after surgery.

Hospitalization:

-The TESE procedure will take 2-4 hours.

-Since several TESE procedures are done each day, your operation could require a wait. This is done to be sure we have looked at your semen sample and the need for your retrieval.

-You will be discharged from the hospital the same day. An adult must accompany you home. You may travel by train, automobile, or plane.

-Wear loose, comfortable clothing.

Post-operative Instructions:

-A small amount of blood and/or drainage from the incision is expected. If you feel it is excessive, please call our office.

-An ice pack will need to be applied to the scrotum for 48 hours following surgery. It may be placed inside the supporter. This will minimize swelling. Bruising may appear.

-You may remove the gauze and scrotal support after the initial 48 hours. You may shower at this point. Reapply the scrotal support after showering.

-You should not drive or work for 1 week following surgery; you may be driven. If your job involves light desk work, you may return in 3-4 days.

-It is common to experience some discomfort 2-3 weeks following surgery. You may resume normal activities as tolerated; however, no sexual activity for 3-4 weeks and avoid sports and heavy lifting for 3 weeks.

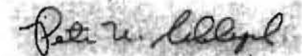
-The athletic supporter should be worn, at all times, for 2-3 weeks following surgery. After 3 weeks, you may wear snug jockey shorts when participating in sports or strenuous activity.

-A low grade fever, up to 101 degrees, is common for the first 2-3 days following surgery. Please remember to cough, deep breathe, and walk.

Follow-up:
-Please phone office and schedule your 1 month follow-up appointment.

Please feel free to contact our office with any questions and/or concerns.

Sincerely,



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TESE FROZEN SAMPLES

PLEASE BE ADVISED

It is a standard practice at Cornell to freeze live sperm, if any are left over after ICSI. However, any samples that are frozen will incur charges for processing and yearly storage charges. In order to help you make a decision as to whether you want sperm frozen please understand:

1. Samples of Testicular sperm that were frozen may not survive the freezing and thawing process. In only 30-40% of cases (for men with low sperm production such as yourself) will sperm survive freeze-thaw and be useful for ICSI.

2. 2 If you go through an ICSI cycle with attempted sperm retrieval in the future and no sperm can be found, frozen testicular sperm may be your only option, beyond that of donor sperm.

3. If you proceed with an IVF cycle using the frozen testicular tissue, we recommend that a backup sperm retrieval operation be scheduled. (In case the sample of frozen testicular sperm has no viability after thawing.)

4. It usually takes at least 6 months with another testicular sperm attempt to allow healing before you can proceed.

FINANCIAL POLICY FOR UROLOGY AND CRM

The Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine (CRM) requires that you pay for your urological procedures in full (including, but not limited to Epididymal/Testicular Sperm Extraction, Percutaneous Needle Biopsy and Ejaculatory Abnormalities). On the first day of your IVF Cycle, you will need to pay by check, cash, money order, travelers check or credit card. Upon completion of your cycle, you will receive itemized insurance forms in the mail. These forms should be sent to your insurance company for reimbursement.

Testicular Sperm Extraction	**$ 14,000.00**	
Check payable to: Urology	$ 12,000.00	Testis Biopsy (multiple)
	$ 500.00	Cytopathology, evaluation of aspirate in operating room
Check payable to: CRM	$ 1,500.00	Sperm identification from testis tissue

Epididymal Aspiration	**$ 9,500.00**	
Check payable to: Urology	$ 8,000.00	Epididymal Sperm Aspiration
	$ 500.00	Cytopathology, evaluation of aspirate in operating room
Check payable to: CRM	$ 1,000.00	Sperm identification from aspiration

Percutaneous Needle Biopsy	**$ 5,500.00**	
Check payable to: Urology	$ 3,500.00	Needle biopsy of testis for sperm retrieval (multiple)
	$ 500.00	Cytopathology, evaluation of aspirate in operating room
Check payable to: CRM	$ 1,500.00	Sperm identification from testis tissue

Ejaculatory Abnormalities	**$ 5,600.00**	
Check payable to: Urology	$ 3,000.00	Rectal Probe electrostimulation
	$ 500.00	Cytopathology, evaluation of aspirate in operating room
	$ 500.00	Anoscopy
	$ 600.00	Bladder catherization for semen retrieval
Check payable to: CRM	$ 1,000.00	Sperm identification from aspiration

Fees for the following procedures:

1. Egg retrieval alone performed after frozen testicular sperm processing determines that sperm retrieval is not needed.

Check payable to: Urology	$ 1,500.00	Physician standby service
Check payable to: CRM	$ 1,500.00	Sperm identification (fresh or cryopreserved)

2. Egg retrieval alone performed after ejaculated sperm processing determines that sperm retrieval is not needed.

Check payable to: Urology	$ 1,500.00	Physician standby service

3. Surgical Pathology test

This is billed separately by NYPH.	$ 400.00	A formal biopsy.

Fees are subject to change

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

CRMI
ATTN: Billing Department

1305 York Avenue, 6th Floor
New York, NY 10021

Subscriber:________________ ID#____________

Patient:________________ Grp#____________

Below is a list of procedure codes and charges related to the proposed procedure for the above named patient. Please send a predetermination of benefits showing coverage for all codes listed.

	CPT CODE	AMOUNT
Epididymal Aspiration		
☐ Epididymal sperm aspiration	54865-22	$ 8,000.00
☐ Cytopathology, evaluation of aspirate in operating room	88172	$ 500.00
☐ Sperm identification from aspiration	89257	$ 1,000.00
Percutaneous Needle Biopsy		
☐ Needle biopsy of testis for sperm retrieval (multiple	54500-22	$ 3,500.00
☐ Cytopathology, evaluation of aspirate in operating room	88172	$ 500.00
☐ Sperm identification from testis tissue	89264	$ 1,500.00
Testicular Sperm Extraction		
☐ Testis biopsy (multiple)	54505-22	$12,000.00
☐ Cytopathology, evaluation of aspirate in operating room	88172	$ 500.00
☐ Sperm identification from testis tissue	89264	$ 1,500.00
Ejaculatory Abnormalities		
☐ Rectal probe electrostimulation	55870	$ 3,000.00
☐ Anoscopy	46600	$ 500.00
☐ Bladder catherization for semen retrieval	51700	$ 600.00
☐ Cytopathology, evaluation of aspirate in operating room	88172	$ 500.00
☐ Sperm identification from aspiration	89257	$ 1,000.00
☐ Physician standby service	99360	$1,500.00
☐ Sperm identification from testis tissue	89264	$1,500.00
☐ Sperm identification from aspiration	89257	$1,000.00

(Fees Subject to Change)

BILLING BULLETIN

The Urology Unit does not participate with any HMO's, PPO or any Commercial insurance. Please contact your insurance company to determine what type of pre-authorization is necessary for your reimbursement. Services rendered by the Urology Unit will be performed out of network at all instances.

You will be asked to make payment in full for the Urologic procedures at the same time you and your spouse are making payment for your IVF cycle, which is day one of the IVF cycle.

1. On the day of your procedure, patients are required by New York Presbyterian Hospital, Admitting department to make an initial deposit for the operating room, recovery room and other hospital expenses. The following amounts represent the minimum deposit required by NYPH. The final charge may exceed these amounts.

Procedure	Deposit Amount
Testicular Sperm Extraction	$5,555.00*
Epididymal Aspiration	$5,555.00*
Ejaculatory Abnormalities	$5,555.00*

OR

a written precertification , precertification/authorization number, authorization, or a referral form from the insurance carrier if you have coverage for the above urologic procedure. After submission of claim to the insurance company, patient will be responsible for the NYPH facility fee if the insurance company does not pay.

*The final total amount will vary depending on the actual hours.

2. You will be billed separately for the Anesthesia cost.

Procedure	*Estimated Minimum Charge
Testicular Sperm Extraction	$ 2,200.00
Epididymal Aspiration	$ 1,500.00
Ejaculatory Abnormalities	$ 800.00

* The "Estimated Minimum Charge" is not the actual charge amount. The final total amount will vary depending on the actual anesthesia hours.

3. Please call your insurance company first to find out if you have benefits for the proposed procedure(s). If you have the benefits and require precertification/predetermination please call (646) 962-3885. Have the following information available:

a. Insurance ID#
b. Subscriber's name
c. Contact person/dept. with telephone# and fax# if available.

4. Health insurance claim forms are mailed to you following your cycle.

(Fees Subject to Change)

10/01/12

INSURANCE INFORMATION

Please Note: All billing and insurance matters will be handled by the Center for Reproductive Medicine. Please see enclosed material on page 8

Reminder: On the day of retrieval, patients will bring to New York Presbyterian Hospital, Admitting department either of the following:

Payment for deposit of $5104.99.

OR

A written precertification, precertification/authorization number, or a referral form from the insurance carrier if you have IVF coverage.

For pre-certification or for billing and insurance matters, please call IVF at (646) 962-3245

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Peter N. Schlegel, M.D.
James J. Colt Professor of Urology
Chairman, Department of Urology
Urologist-in-Chief

Brady Urologic Health Center
525 East 68th Street, Starr 900
New York, NY 10065

Telephone: 212 746-5491
Fax: 212 746-8425
E-mail: pnschleg@med.cornell.edu

Insurance & Testing Information for TESE/MESA Procedures

New York State Empire Government Plan (NYSHIP) United Health Care Empire Plan

Patients opting to use their fertility benefits must enroll in the Center for Excellence Program, upon enrolling an authorization number will be provide to you.

Oxford Optum:

Dr. Schlegel does not participate with oxford but patients with this plan can seek reimbursement. For additional information regarding Oxford (Optum) please call 877-512-9340. We encourage patients to contact their insurance companies and inquire about their fertility eligibility and coverage for fertility. .

Testing that may be required before or after TESE/MESA

Semen Analysis: A collection of semen to determine the count, mobility and morphology of the semen.

Scrotal Ultrasound (Covered by most insurance)

Testosterone: Hormone test (Covered by most insurance)

Estradiol: Hormone test (Covered by most insurance)

FSH: Hormone test (Covered by most insurance)

The estimate of charges for TESE /Mesa does not include any additional services nor procedures