UCLA Ronald Reagan Medical Center

# OPERATING ROOM OBSERVATION REQUIREMENTS
# SURGEON'S OFFICE GUIDE

**Observation requests are only for visiting Medical Students and visiting Physicians.**

1. Instruction on submitting Observation Requests
    1. **Forms** – All required forms (listed below) must be filled out and signed for visiting Medical students and visiting Physicians. Please email all completed forms to Observation@mednet.ucla.edu .
    2. **Badges** – For observations of duration of more than 30 days; a UCLA badge is required. The surgeon's office is responsible for obtaining a UCLA badge.
    3. **Scrubs** – Our office will contact you to request badge sizes and a PIN code for ScrubEx machine use.
    4. **Medical Students** – In addition to the required forms (below), an O.R. orientation is required and should be scheduled by the surgeon's office with Lorie Paset. *Except for resident interviews.*
    5. *Any requests for non-medical observers must be approved by the Operating Room Services Director.*

**Required forms for observation requests are:**

1. Observation Request form (Page 3 of this packet)
    a. To be filled out by the requesting Surgeon's Office
    b. Must include Surgeon's signature
2. Confidentiality Statement (Pages 4-5 of this packet)
    a. To be filled out and signed by the observer
3. Precautions & Hepatitis B Statement (Page 6 of this packet)
    a. To be filled out and signed by the observer
4. Active negative TB Test for observer or negative Chest X-ray
    a. Provided by the observer
    b. Negative TB Test/Chest X-ray is active for ONE year. Any TB Test older than one year will not be accepted

II. Instructions for visiting Medical Students and visiting Physicians (see page 2 of this packet for the Visiting Physician/Medical Student Guide)

1. **Lockers** – a temporary shared locker will be assigned upon your arrival. Do not bring valuables with you as these lockers are shared and other visitors will have access to the locker. Lock on the locker must remain on the assigned locker.
2. **Badge** – Badges for people observing cases from 1 to 30 days will be assigned a temporary badge by the Main O.R. Over 30 day observations will require a UCLA badge obtained by the surgeon's office.
3. **Scrubs** – Your surgeon's office will inform you on the PIN and Access code to be used for scrubs. *All Scrubs must be returned at the end of the day using your Access code and PIN.*

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# OPERATING ROOM OBSERVATION REQUIREMENTS
# VISITING PHYSICIAN/MEDICAL STUDENT GUIDE

**Observation requests are only for visiting <u>Medical Students</u> and visiting <u>Physicians.</u>**
**<u>Fill out the required forms for observation requests provided by the surgeon's office:</u>**

1. Confidentiality Statement (Pages 4-5 of this packet)
    a. To be filled out and signed by the observer
2. Precautions & Hepatitis B Statement (Page 6 of this packet)
    a. To be filled out and signed by the observer
3. Provide an active negative TB Test or negative Chest X-ray for person observing
    a. Negative TB Test/Chest X-ray is active for ONE year. Any TB Test older than one year will not be accepted

I. Instructions for visiting Medical Students and visiting Physicians

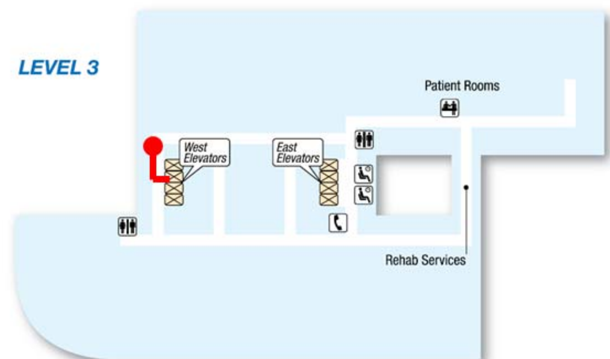
1. **Lockers** – a temporary shared locker will be assigned upon your arrival. Do not bring valuables with you as these lockers are shared and other visitors will have access to the locker. Lock on the locker must remain on the assigned locker.
2. **Badge** – Badges for people observing cases from 1 to 30 days will be assigned a temporary badge by the Main O.R. Over 30 day observations will require a UCLA badge obtained by the surgeon's office.
3. **Scrubs** – Your surgeon's office will inform you on the PIN and Access code to be used for scrubs. *All Scrubs must be returned at the end of the day using your Access code and PIN.*

II. Where to go – *please see maps below*

1. **Check in** at the Main Operating Room's Front Desk on the second floor
    a. Take the West Public Elevators to the 2nd floor
    b. Turn left upon exiting the elevators and turn left again
    c. Walk down the hall and make a left turn at the Pharmacy
    d. Turn right after passing the East elevators
    e. The O.R. Front Desk will be on the left
2. For scrubs and locker room:
    a. Take the West Public Elevators to the third floor
    b. Turn right upon exiting the elevator
    c. The locker room (3311 RRUMC) will be on your left hand side

<u>To the Main O.R.:</u>

<u>To the Locker Room:</u>



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# OPERATING ROOM OBSERVATION REQUIREMENTS REQUEST FORM

**DATE**: ____ /____ /____

**TO**: Samuel Wald, M.D.
Main Operating Room
**Physicians & Medical Students** – email requests to Observation@mednet.ucla.edu
**Vendors –** fax requests to **Tim** Phone (310) 26**7**-**8303** Fax (310) 26**7**-**3609**

**FROM**: ______________________________ **EXT**: ________________

Please allow _______________________________________________________ ☐ Male ☐ Female
**(Visitor Name and Title)**

from ______________________________________________________________________________
**(Company Name and Location)**

to observe surgery on _____________________________________________________________
**(Patient Name and/or Case Number)**

scheduled for surgery on ____ /____ /____.
**(Date)**

This request is for a visiting ☐ physician, ☐ resident, ☐ medical student, or

☐ Other (specify) ________________________________________________________

who will be observing numerous surgeries. The following dates indicate the duration of visitation: ____ /____ /____ through ____ /____ /____.

☐ Non-medical visitors (i.e. film crews, reporters, medical photographers, etc.) to the Operating Room, the patient has been advised And a signed authorization is in the chart.
**(NOTE: THIS MUST BE CHECKED, IF NON-MEDICAL)**

Thank you for your consideration.

________________________________ ________________________________
**(Type/Print Name of Requesting Surgeon)** **(Signature of Requesting Surgeon)**

***<<For Office Use Only>>***

Approved: ____________________________________________ ____ /____ /____
O.R. Medical Leadership Date

Name (Print): __________________________________________

☐ TB
☐ Confidentiality
☐ Pathogens
☐ Orientation
☐ Scrub
☐ Badge ☐ N/A

# OPERATING ROOM OBSERVATION REQUIREMENTS CONFIDENTIALITY STATEMENT (For Non-Workforce Members)

The federal Health Insurance Portability and Accountability Act ("HIPAA") and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient. In certain circumstances, HIPAA allows the disclosure of limited patient information in order to carry out treatment, education, research, public health, or health care operations activities without obtaining the patient or subject's authorization.

***Confidential Patient Information includes:*** Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note this information is defined in the Privacy Rule as "protected health information.") Examples include but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computerized patient data;
- Visual observation of patients receive medical care or accessing services; and
- Verbal information provided by or about a patient.

I understand and agree that this document establishes a Confidentiality Agreement between me____________________________________ [insert name of Individual] a representative of _______________________________________ [insert name of employer] and UCLA and sets forth the understanding regarding the protection of any confidential information that Individual may have access to while performing services at UCLA with the following purpose:

_____________________________________________________________________________________

1. I understand that I will be granted access to, or otherwise become acquainted with, the following information ("Information") relating to UCLA patients:

- ☐ Clinical/medical information
- ☐ Insurance and Billing information
- ☐ Scheduling information
- ☐ Visual observation of patients receiving medical care or accessing services
- ☐ Other (describe)___________________________________

# OPERATING ROOM OBSERVATION REQUIREMENTS CONFIDENTIALITY STATEMENT (For Non-Workforce Members)

It is understood and agreed that except as required by law, I will use and hold all Information in strict trust and confidence, and will use such information only for the purposes contemplated herein, and not for any other purpose.

2. I acknowledge that it my responsibility to respect the privacy and confidentiality of Information received from UCLA. I will not access, use or disclose patient or other confidential information unless I am authorized or permitted to do so by law or as authorized by the patient I further understand that I am required to immediately report any information about unauthorized access, use or disclosure of confidential patient information to UCLA.

3. I agree to not disclose the Information to any other individuals.

4. Neither the release of any Information hereunder or the act of disclosure shall constitute a grant of any license under a trademark, patent, or copyright or application of the same.

5. I understand and acknowledge that, should I breach any provision of this Confidentiality Statement, I may be subject to civil or criminal liability.

______________________________ ______________________________

(Signature) (Date) (Time)

______________________________

(Print Name)

UCLA Ronald Reagan Medical Center

# OPERATING ROOM OBSERVATION REQUIREMENTS PRECAUTION AND HEP B STATEMENT

## I. Knowledge Statement of Bloodborne Pathogens And Universal Precautions

I have a theoretical and clinical knowledge of bloodborne pathogens and universal precautions.

(Signature) (Date) (Time)

(Print Name)

## II. Hepatitis B Vaccine Verification/Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials that I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine however; I have declined the hepatitis B vaccination. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine series I will arrange this with my employer/institution.

(Signature) (Date) (Time)

**-OR-**

I have completed the hepatitis B vaccination series.

Completion date of HBV series

(Signature) (Date) (Time)