Patient Sticker

SURGICAL / PROCEDURE BOOKING & PRE-OP ORDERS

Tele: 1-978-521-8202
Fax: 1-978-521-3690

Patient Name: ______________________________ DOB: __________ Age: _____ Tele # ____________ Cell # __________

Surgeon: ____________________________ PCP: __________________________

Type of admission requested:
☐ AM Admission
☐ Surgery Day
☐ Minor Surgery

Allergies: ____ Latex allergy: ☐Yes ☐No

Diagnosis: ____

Procedure: ____

Equipment request: ____

Date / Time of Procedure: _________________Estimated Surgical time: _____________

Pre-Op testing appointment: _____________________ Call: Cell / Home phone

Anesthesia: ○ General ○ Spinal ○ Local / MAC ○ Dr. Loc

Insurance Company: ____________________________ Subscriber: ____________________ Approval #: ________________
Workman's Comp Injury date: ________________ Employer: ____________________ Phone #: _____________
Auto Accident Injury date: ________________ Ins. Agent: ___________________ Phone #: _____________

HISTORY AND PHYSICAL

H&P must be performed, documented (must be repeated if > 30 days from surgery) and **in pt. record 24 hours prior to surgery.**
H & P: dictated on: ◘ Hospital system ◘ Office system **Will dictate on:** ◘ Hospital system ◘ Office system
☐Cardiac / ☐Medical consult needed: Please indicate if a consult requested
Physician: _______________________Consult for: ___________________________________Appointment Date: ________
Physician:: ______________________Consult for: ___________________________________Appointment Date: ________

Please advise office to forward finding of consult to Pre-admission testing. Fax # 1-978-521-3690

PRE-PROCEDURE ORDERS

□ Anesthesia Consult: ___________________________________ □ Physical Therapy for: __________________________
□ Discontinue: ○ASA ○ Coumadin ○Anti-inflammatory RX _____days prior to surgery date.
□ Other: ____

PRE-SURGICAL LAB TESTING ORDERS

Lab work to be done at: ☐MVH ☐ PMA ☐ Other __________ Please fax results to MVH prior to Pre-adm testing date.

□ Electrolyte Panel	□ PT / INR	□ Chest X-ray
□ Basic Metabolic Panel (Calcium, Total)	□ PTT	□ X-ray other ______________
□ CBC	□ HCG	□ EKG: read by _____________
□ ESR (sed rate)	□ UPT	□ Type and Screen
□ Random Glucose	□ U/A	□ Type and Crossmatch _____Units
□ LFT (AST, ALT, T Bil)	□ U/A w/ MICRO	□ Autologous donation _____Units

□ Other: ____
☐ **LAB WORK PER ANESTHESIA GUIDELINES**

DAY OF PROCEDURE ORDERS

□ PT □ PTT / INR □ Finger stick Glucose □ Venodyne boots □ other: ____
□ Pre-op Meds /**Antibiotic order**: ____
□ IV Saline Lock Additional orders: ____
____

Date / Time: ____________________ Physician Signature: ____

Date / Time: ____________________ RN noted by: ____

cld7-09