# SURGICAL PROCEDURE BOOKING PAT & PRE-OP ORDERS

***Complete all areas, fax to (978) 521-8636.*** ***ONCE RECEIVED*** *we will confirm date/ times of procedure with your office.*

Patient Name:_____ DOB: _____ Tele #: _____ _____
Home Cell

Surgeon: _____ PCP:_____ ☐ **Interpreter Needed**

| **Date of Procedure** | | Time of Procedure | | Pre-OP testing Date /Time | |
|---|---|---|---|---|---|
| **DIAGNOSIS** | | | | | |
| **PROCEDURE** | | | | **Length of Surgical Time**: | |

**EQUIPMENT REQUESTED**

☐ **None or Specify:**

**INSURANCE**

| COMPANY | | Policy # SUBSCRIBER | | APPROVAL # | ☐ None Required |
|---|---|---|---|---|---|

**ANESTHESIA**

☐ General ☐ Local / MAC
☐ Spinal ☐ Dr. LOC

**PATIENT STATUS**

☐ Surgical Day Care ☐ AM Admit
☐ Minor Procedure

**ALLERGIES**

| **FOOD** | ☐ NKA | **LATEX** | ☐ Yes ☐ No |
|---|---|---|---|
| **DRUG** | ☐ NKA | | |

**HISTORY & PHYSICAL**

**Must be completed no more than 30 days prior to procedure date.** **Fax to Pre Admission testing @ 1- 978-521-3690**

**CONSULTS**

☐ Medical/Cardiac: Consultant: _____ Reason: _____ Appt. Date: _____
☐ OTHER: Consultant: _____ Reason: _____ Appt. Date: _____
☐ Anesthesia ☐ Physical Therapy for: _____

**PRE-PROCEDURE ORDERS**

Discontinue: ☐ ASA ☐ Coumadin ☐ Anti-Inflammatory RX including _____ ; _____ days prior to surgery
Other: _____

**PRE-PROCEDURE LAB TESTING ORDERS**

☐ **NONE** or ☐ Per Anesthesia Protocol or ☐ As specified below & done at: ☐ MVH ☐ Other: _____ **if other please fax results to PAT @ 978-521-3690**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | LFT (AST, ALT, T Bil | | ESR (Sed Rate) | | PT/ INR | | UPT | | Chest X-Ray |
| | Basic Metabolic Panel (Calcium Total) | | Random Glucose | | PTT | | U/A | | X-Ray Other: |
| | CBC | | Electrolyte Panel | | HCG | | U/A w micro | | EKG: Read by |
| | Type and Screen ____ Units | | Type and Cross match ____ Units | | | | Autologous donation ____ Units | | |
| | Other: Specify | | | | | | | | |

**DAY OF PROCEDURE ORDERS**

☐ NONE ☐ PT/ INR ☐ PTT ☐ Glucose Finger Stick ☐ IV Lock
☐ Pre- Op Medications / Antibiotic: _____
☐ Other: _____

Date/ Time: _____ Physician Signature: _____
Date / Time: _____ Signature RN Noting: _____

REVISED 8/27/13