ORLEANS
Community Health

Medina Memorial
Hospital

Surgical Scheduling & Pre-op Orders
Fax Number (585) 798-8439

Patient Last **Name:** _____ Patient First Name: _____ Middle Initial: ____

Gender: ☐ Male ☐ Female   Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Number: _____

Insurance Carrier: _____

Authorization Number: _____

Surgeon: _____ AssistantSurgeon/CRNFA: _____

Date of Surgery: _____ Time of Surgery _____ Time of arrival _____

Admitting Diagnosis _____

Additional Co-Morbidities :☐HTN ☐DM ☐CAD ☐CHF ☐Sleep Apnea ☐other_____

Primary Procedure: _____

Additional Procedure: _____

Admission Type: ☐ Same Day Surgery   Procedure length_____
           ☐ In-Patient/AM Admit

Pre-op **Medical Clearance** by: _____

Anesthesia desired: ☐ Local ☐ MAC ☐ Bier block ☐ General ☐Spinal ☐RN/MD conscious sedation

Radiology desired: ☐yes ☐ no

Additional equipment/special needs: _____

Pre-admission testing desired: **Pre-op testing date:** _____ time: _____

Labs:

☐ CBC   ☐ CBC w/DIFF   ☐ PT/PTT   ☐ PT/INR   ☐ CXR: medical diagnosis needed_____

☐ Hgb, hct   ☐ BMP ☐ CMP

☐ UA ☐ Serum HCG   ☐ Type &Screen/Cross_____units   ☐ EKG: medical diagnosis needed_____

☐other_____

Pre-Anesthesia Orders:

☐ If patient is diabetic, check blood glucose level and document on admission

☐ Stat urine HCG on arrival for women of childbearing age & have not had hysterectomy

☐ Start IV of 1000ml of Lactated Ringers at 100cc/hr on admission

☐ Pre-op Medications/ Antibiotic:

_____

☐ Sequential Compression Device

Physician Signature:_____ Date:_____ Time:_____