COFFEE REGIONAL MEDICAL CENTER

# AMBULATORY SURGERY UNIT
# LAB & DIAGNOSTIC TESTS

1PO

**Pre−Admission Labs and Diagnostics**

Pre−Surgery Diagnosis:_____

Scheduled Procedure:_____

Date of Procedure:_____Allergies:_____

Precertification #:_____

❑ No Lab Tests Required

❑ Anesthesiology Consultation(Patients with Medical or Surgical issues) ❑ MRSA Screen

❑ Hgb/Hct
❑ CBC without diff
❑ CBC w/diff
❑ PT
❑ PTT
❑ CMP
❑ BMP
❑ Blood Glucose
❑ FSBS Day of Surgery
❑ Uric Acid
❑ Urinalysis w/ Micro

❑ Urine HCG
❑ Serum HCG
❑ Quant. HCG
❑ HBsAg
❑ Sickle Cell Screening
❑ Amylase
❑ Lipase
❑ Hepatic Panel
❑ Other Lab

_____

❑ Type and Screen
❑ Crossmatch ___# units PRBCs
❑ Crossmatch ___# units autologous Blood

❑ Other blood products_____
❑ CXR
❑ KUB
❑ Other X−ray_____

❑ Ultrasound _____
❑ 12 lead ECG
❑ PFT

**Blood for pre−transfusion testing must be drawn within 48 hours of surgery. Typed and Screened blood can only be held 48 hours.**

**Pre−Surgery Orders ❑ OPS (Outpatient Surgery) ❑ IP (Inpatient) ❑ Unknown Length of Stay**

Vital Signs: ❑ Per Protocol ❑ Other _____

Diet: ❑ NPO ❑ NPO after _____

❑ LR at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr
❑ NS at KVO or ❑ 100ml/hr ❑ 200ml/hr ❑ _____ml/hr
❑ NS (500ml bag) at KVO via microdrip tubing for renal patient

**Medications:**

❑ Pre−Op Antibiotic in ASU/OR holding area_____
❑ Bacterial Endocarditis Prophylaxis:_____❑ Consult Pharmacy/Anesthesia
❑ Ancef ❑ 1GM ❑ 2GM IV in OR
❑ **If PCN / B−Lactam Allergy OR ❑ Patient at Increased risk for infection**
❑ Vancomycin 1GM IV to be started within 120 minutes of incision
or
❑ Cleocin 900MG IV to be started within 30 minutes of incision
❑ Tylenol suppository by weight in ASU/OR
❑ Other_____

**Preparation:**

❑ Incentive Spirometry: Instructions/pre−admit
❑ Thigh / Knee High TED hose
❑ Sequential Compression Device in OR

**Consult Anesthesia for post−op pain block**

❑ Yes ❑ No

_____
(Type of block)

**Minimum Testing Guidelines (Anesthesia Service): These guidelines are suggested minimums. They are not replacement for medical judgment, and the patient's medical history and/or the proposed surgical procedure may indicate additional laboratory or diagnostic testing**.
**No pre−operative laboratory testing** is required for asymptomatic patients without significant medical problems who are less than 40 years of age.
**ECG**: Males aged 40 and above require an ECG. Females aged 50 and above require ECG
**Pregnancy Test**: A pregnancy test is required for all menstruating females, unless not indicated due to sterility. Serum HCG if blood is drawn for other tests, otherwise it will be a urine HCG.
**Labs:** CBC and BMP are required for patients age 65 and older. BMP is required for diabetic, renal and/or hypertensive patients. FSBS is required day of surgery in diabetic patients, except in patient who have a BMP done day of surgery.
**Copies:** A copy of a CXR and/or ECG completed in the past 6 months is sufficient in the absence of a change in the patient's health status. A copy of lab work completed in the past 30 days is sufficient in the absence of renal disease. Renal patients must have a K+ completed after their last dialysis treatment before the date of surgery.
**IVF:** Every patient over age 10 is required to have an IV of LR at KVO rate. Renal patients must have NS at KVO rate



PO_9100_EFR
Rev. 10/23/2017

COFFEE REGIONAL MEDICAL CENTER

# ASU UNIVERSAL MEDICATION FORM

1MRR

Name: _____ Date of Birth: _____

| ALLERGIES (DESCRIBE REACTION) | ALLERGIES (DESCRIBE REACTION) |
|---|---|
| | |
| | |
| | |

**My Primary Physician's Name is:**_____

**My Pharmacy Name is:**_____

**Bring all medicines with you to Pre−Op and Surgical appointments.**
**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:** Prescription and over−the−counter medications (examples: aspirin, antacids). Also include herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

| Name of Medication | Dose | Route | How Often | Notes: Reason for Taking, etc. | Date Stopped |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Signature



Rev. 03/11/2015

**COFFEE REGIONAL MEDICAL CENTER**

**ASU PRE−ADMISSION WELCOME & RULES**

## Welcome to the Pre−Admission Testing Office

Soon you will be undergoing surgery at Coffee Regional Medical Center. You and your physician have elected to have you admitted the morning of your scheduled surgery. In order for us to plan for your care, it is necessary that we meet with you before your surgery. You will be asked to report to the Ambulatory Surgery Department for pre−admission (which includes having a personal interview by a nurse, necessary lab work, x−rays and an EKG done if ordered by your physician). All arrangements will be directed from this area. We look forward to seeing you.

## Welcome to the Ambulatory Surgery Department

In order that we might make your stay with us as pleasant as possible, we need to make you and your family aware of the following:

- Proper rest is important to your recovery; therefore, visitors are limited to two (2) per patient. For your safety, we ask that visitors be free of colds, flu, etc. **ONE PARENT / GUARDIAN MUST BE IN THE DEPARTMENT AT ALL TIMES FOR ALL PATIENTS UNDER 18 YEARS OF AGE.**
- Your requests are very important to us. However, once in a while a message gets lost. If your need has not been met within 15 minutes, please ask again.
- We want you to be comfortable and are happy to medicate you, but we do not do it without your request. Please let us know if you are experiencing pain or discomfort.
- **WE WILL CHECK ON YOU FREQUENTLY.** It may sometimes be necessary to awaken you so that we can monitor your status.
- This is a smoke−free hospital and smoke−free campus. **ABSOLUTELY NO SMOKING IS PERMITTED ON CRMC CAMPUS!**
- For your privacy, all the information concerning your stay at CRMC is confidential. The only information the nurses can give is a condition report (stable−guarded−critical).
- For your safety, the hospital holds frequent fire drills so that all staff will know what to do should a real fire occur. Please do not be alarmed by the sound of the fire bells or the sound of all the doors being closed. This is just a routine part of the drill.
- When discharge orders are received, we will arrange for your discharge as soon as possible. Your instructions, prescriptions and answers to any questions will be given to you by your nurse. Please remind us to return your home medications and / or valuables.
- Patients are furnished with meals, ice and beverages according to Doctor's orders. There is a cafeteria and snack bar located on the first floor for the family and visitors to use.

***Cafeteria Hours:***

Breakfast − 07:30 a.m. − 09:30 a.m.
Lunch − 11:30 a.m. − 01:30 p.m.
Grill − 11:30 a.m. − 05:30 p.m.

COFFEE REGIONAL MEDICAL CENTER

# CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES

3CNT

**DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS**

A. (1) I acknowledge and understand that the following procedures which have been described to me are to be performed on the patient:

_____

_____

_____

and that as a result of the performance of the procedures there is a material risk that the patient may suffer INFECTION, ALLERGIC REACTION, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, DISFIGURING SCAR OR BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

(2) I acknowledge and understand that during the course of the procedures described in paragraph (A), conditions may develop which may reasonable necessitate an extension of the original procedures or the performance of procedures which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

B. (1) I acknowledge and understand and duly evidence in writing by executing this form that I have been informed in general terms of the following:

−1− A diagnosis of the condition requiring the procedures;
−2− The nature and purpose of the procedures;
−3− The material risks of the procedures (see paragraph (A) above);
−4− The likelihood of success of the procedures;
−5− The practical alternatives to such procedures; and
−6− The prognosis if the procedures are rejected;

and that such was provided through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or medical personnel under the supervision or control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician assistants, trained counselors, or patient educators.

C. ** (1) I acknowledge and understand that in addition to the material risks of the procedures listed in paragraph (A) above there may be other risks attendant to the performance of the procedures as there are with any surgical or diagnostic procedure.

D. ** (1) I acknowledge that there are practical alternatives to the procedures described in paragraph (A) which alternatives reasonably prudent Physicians generally recognize and accept.

E. ** (1) I acknowledge and understand that the physician, medical personnel, and other assistants will rely on the patient's statements, medical history, and other information provided by the patient in determining whether to perform the procedures or the course of treatment for the patient's condition and in recommending the procedures which have been explained

F. ** (1) I acknowledge and understand the practice of medicine is not an exact science; and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME concerning the results of the procedures.

G. ** (1) I also consent to diagnostic studies, tests, anesthesia, x−ray examinations, and any other treatment or courses of treatment relating to the procedure described in paragraph (A) which may be prescribed or ordered.

H. ** (1) I also consent that any tissues, specimens, members, etc removed in the course of any procedure may be tested, retained, or preserved for Scientific or teaching purposes and then disposed of within the discretion of the physician, facility, or other health care provider.

Patient Name

COFFEE REGIONAL MEDICAL CENTER

# CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES

I. ** (1) I acknowledge and understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.

J. ** (1) **I acknowledge that some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.**

I HAVE BEEN GIVEN SUFFICIENT OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. *** ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION, INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATING TO THE PROCEDURES DESCRIBED HEREIN.*

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW DR. _____ OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBED OR OTHERWISE REFERRED TO HEREIN.

| Witness Signature | Date | Time |
|---|---|---|
| Signature of Patient or Other Person Authorized to Sign | Date | Time |

I HAVE DISCUSSED THE RISKS, BENEFITS AND ALTERNATIVES OF THE PROCEDURE WITH THE PATIENT.

| Physician's Signature | Date | Time |
|---|---|---|

Additional materials used, if any, during informed consent process for this procedure include: _____

Person giving consent: _____

Patient Name

COFFEE REGIONAL MEDICAL CENTER

# NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

3OR

SURGERY:_____ DATE OF SURGERY:_____

Height_____ Weight_____ Marital Status_____ V/S: T_____ P_____ R_____BP_____SpO2_____

1. Please list the operations you have had in your life, including: Dates (month/year), Doctor, Hospital:

   Organ Transplant? ❑ Yes ❑ No Which organ:_____
2. Please list any medical conditions you have or have had (high blood pressure, diabetes, heart attack, etc.)

3. Are you allergic to latex? ❑ Yes ❑ No Are you allergic to any food, medications, or other (specify what and type of reaction)?

4. Have you or anyone in your family ever had a reaction to a local or general anesthetic? ❑ Yes ❑ No

5. Have you ever been diagnosed with cancer? (specify if current or past) ❑ Yes ❑ No

6. Do you smoke? ❑ Yes ❑ No How many packs per day?_____For how many years? _____
   Have you recently quit smoking? ❑ Yes ❑ No How long ago & for how long have you quit?_____
   Do you chew tobacco / snuff? ❑ Yes ❑ No Do you use "street drugs"? ❑ Yes ❑ No
   If so, explain_____ How much beer, wine, or liquor do you drink per day? _____

7. Have you currently or in the past been treated for a mental / emotional condition? ❑ Yes ❑ No

8. Have you had a chest cold or chest infection in the last month? ❑ Yes ❑ No
   Do you have chronic bronchitis, asthma, COPD, emphysema, or sleep apnea? ❑ Yes ❑ No
   Do you take medicine for breathing or use a CPAP / BiPAP machine? ❑ Yes ❑ No

9. Have you ever been diagnosed with Tuberculosis (TB)? ❑ Yes ❑ No
   Have you been exposed to Tuberculosis (TB)? ❑ Yes ❑ No
   Have you ever been treated for Tuberculosis (TB)? ❑ Yes ❑ No
   Have you been experiencing night sweats, coughing up blood, & a persistent cough for > 3 weeks? ❑ Yes ❑ No

10. Have you ever had trouble with your heart? (Heart attack, irregular heart beat, Mitral Valve Prolapse,Congestive Heart Failure (CHF), heart murmur, congenital defects, etc? ❑ Yes ❑ No
    Have you ever taken medications for your heart? ❑ Yes ❑ No
    Do you ever have pain or pressure in your chest? ❑ Yes ❑ No

11. Have you ever had high blood pressure requiring treatment? ❑ Yes ❑ No

12. Have you ever had any liver disease (hepatitis, yellow jaundice, etc.)? ❑ Yes ❑ No

13. Have you been diagnosed with HIV / AIDS? ❑ Yes ❑ No

14. Do you take medications for heartburn, reflux, ulcers, hiatal hernia, or indigestion? ❑ Yes ❑ No

15. Have you ever had a stroke, mini−stroke, seizure, or frequent headaches? ❑ Yes ❑ No

16. Do you have any paralysis or severe numbness/weakness in your arms or legs? ❑ Yes ❑ No
    Do you have a neuromuscular disease? (Parkinson's, Multiple Sclerosis, Myasthenia Gravis, etc.) ❑ Yes ❑ No
    Do you have arthritis? ❑ Yes ❑ No
    Are you under the care of a Rheumatologist? (Lupus, Gout, Rheumatoid Arthritis, Fibromyalgia) ❑ Yes ❑ No

COFFEE REGIONAL MEDICAL CENTER

# NURSING/ANESTHESIA PATIENT HISTORY QUESTIONNAIRE

17. Are you limited to which arm you can have a blood pressure or needlestick? ❑ Yes ❑ No
18. Do you have "sugar" diabetes (problems with your blood sugar)? ❑ Yes ❑ No
19. Do you have thyroid disease? ❑ Yes ❑ No

20. Do you bleed easily or take a blood thinner? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No
Have you been diagnosed with anemia, sickle cell disease or carry sickle cell trait? ❑ Yes ❑ No
Have you ever had a blood clot? ❑ Yes ❑ No Family history of blood clots / blood clotting disorder? ❑ Yes ❑ No

21. Have you recently been treated for or currently have head lice? ❑ Yes ❑ No

**FOR WOMEN:** 22. Are you pregnant or could you be? ❑ Yes ❑ No
Do you have menstrual cycles or had a menstrual cycle in past 6−12 months? ❑ Yes ❑ No
Have you had a tubaligation or hysterectomy? ❑ Yes ❑ No
Are you currently breastfeeding? ❑ Yes ❑ No

23. Do you have loose/chipped teeth? ❑ Yes ❑ No Wear dentures? (Upper/Lower) ❑ Yes ❑ No
Wear a prosthesis? ❑ Yes ❑ No Wear glasses? ❑ Yes ❑ No Contacts? ❑ Yes ❑ No
Blind? ❑ Yes ❑ No Cataracts/Glaucoma? ❑ Yes ❑ No Have body piercings? ❑ Yes ❑ No
Have trouble hearing? ❑ Yes ❑ No Wear hearing aide? ❑ Yes ❑ No Deaf? ❑ Yes ❑ No

24. Are you on a special diet? ❑ Yes ❑ No If so, what kind?_____
Difficulty swallowing? ❑ Yes ❑ No Eating disorder? ❑ Yes ❑ No
Unplanned weight loss of 10 pounds or more? ❑ Yes ❑ No

25. Do you have any problems with your skin? (eczema, psoriasis, etc.) Rash, burns, lesions, cuts, or bruises? ❑ Yes ❑ No
Do you have any chronic wound(s) or bed sores? ❑ Yes ❑ No
Have you been treated for Methicillin−Resistant Staphylococcus Aureus (MRSA) or Vancomycin−Resistant Enterococci (VRE)? ❑ Yes ❑ No

26. Do you have kidney disease? (kidney failure, polycystic kidney disease, etc.) ❑ Yes ❑ No
Do you have a history of kidney stones? ❑ Yes ❑ No
Do you have problems urinating? (burning, leaking, incontinence, blood in urine, etc.) ❑ Yes ❑ No
Any problems with your bowels? (constipation, diarrhea, bleeding, irritable bowel, etc.) ❑ Yes ❑ No

27. Religion _____Any religious "do's or don'ts" regarding your treatment? ❑ Yes ❑ No

28. Do you need assistance from someone or use an assistive device? (cane, walker, etc.) ❑ Yes ❑ No
Do you live alone? ❑ Yes ❑ No Who will assist with your care after surgery?_____
Who will provide transportation home from your procedure? _____
Do you receive nursing care at home? ❑ Yes ❑ No What agency?_____

29. Are you an Organ Donor? ❑ Yes ❑ No
Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No Does the hospital have a copy? ❑ Yes ❑ No

30. Have you been exposed to communicable diseases (chicken pox, measles, etc.) recently? ❑ Yes ❑ No

31. Have you had a flu shot within the last year? ❑ Yes ❑ No When?_____
Have you ever had a pneumonia vaccine? ❑ Yes ❑ No When?_____

**FOR MINORS:** 32. Are there any guardianship/custody issues? ❑ Yes ❑ No
33. Are his/her immunizations (shots) up−to−date? ❑ Yes ❑ No

34. Are you currently in pain or having discomfort? ❑ Yes ❑ No Where:_____
What level is the pain? (Circle One) No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

**Patient Signature:**_____ **Date:**_____

**Nurse Signature:**_____ **Date/Time:**_____

Pre and Post Op Teaching Given ❑ Yes ❑ No Patient/guardian/spouse/other verbalizes understanding? ❑ Yes ❑ No

COFFEE REGIONAL MEDICAL CENTER

# OUTPATIENT OBSERVATION / SURGERY

1HPRPT

Patient Name: _____

Chief Complaint: _____

**MEDICAL HISTORY**

Present Illness: _____

Past History: _____

Family History: _____

Psychosocial: _____

Immunizations: _____

Current Meds: _____

Allergies: _____

**REVIEW OF SYSTEMS**

SKIN:

HEENT:

RESP:

CV:

GI:

MS:

GU:

GYN:

NEURO:

PSYCH:

**PHYSICAL EXAM** Vital Signs: BP _____ Pulse _____ Resp. _____ Temp. _____

Skin: _____ Abdomen: _____

Head/ Neck: _____ GU: _____

Chest: _____ MS: _____

Heart: _____ Neuro: _____

Lungs: _____

Admitting DX: _____

Treatment Plan: _____

**PHYSICIAN SIGNATURE** **DATE** **TIME**

**DISCHARGE SUMMARY**

Diagnostics: _____

Procedures/ Rx: _____

Discharge DX: _____

D/C Status: _____

Instructions: _____

Activity: _____ Diet: _____

Meds: _____

Follow−up: _____

**PHYSICIAN SIGNATURE** **DATE** **TIME**

COFFEE REGIONAL MEDICAL CENTER

# NURSING / ANESTHESIA
## CRMC Sleep Screening Questionnaire

1ANES

**SURGERY:_____ DATE OF SURGERY**:_____

PLEASE COMPLETE THE QUESTIONNAIRE TO THE BEST OF YOUR ABILITY. IT WILL BE REVIEWED BY A NURSE AND ANESTHESIA PROVIDER PRIOR TO YOUR SURGERY. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.

**1. SNORING:**
Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

**2. TIRED**
Do you often feel ***tired***, fatigued or sleepy during daytime?

Yes No

**3. OBSERVED**
Has anyone ***observed*** you stopping breathing during your sleep?

Yes No

**4. BLOOD PRESSURE**
Do you have or are you being treated for high blood ***pressure***?

Yes No

**5. BMI −**
BMI more than 28?

Yes No **BMI Score_____**

**6. Age**
***Age*** over 50 years old?

Yes No

**7. NECK CIRCUMFERENCE**
***Neck*** circumference greater than 17 inches for male, 16 inches for female?

Yes No

**8. GENDER**
***Gender*** −male?

Yes No

SCORE:_____ (Score is number of Yes responses)

❑ **HIGH RISK OF OSA − YES TO SIX (6) OR MORE ITEMS−**
**Refer patient to their preferred sleep lab for further study/treatment prior to surgery**

❑ LOW RISK OF OSA − YES TO LESS THAN SIX (6) ITEMS

❑ I understand that I am high risk for OSA but refuse further sleep testing and understand that admission after surgery may be necessary.

_____

Patient signature Date/Time

Patient Name and DOB



ANES_9183_EFR
Rev. 07/15/2013

COFFEE REGIONAL MEDICAL CENTER

# PRE−SURGICAL CASE REQUEST

CALL TO SCHEDULE CASE AT EXT 6919

1SCR

Fax Medical Clearance, Orders, Medication List and Case Request to OR @ 383−5632 and Registration @ 389−2165

| DATE: | PATIENT NAME: | | Surgeon: |
|---|---|---|---|
| DOB: | SOCIAL SECURITY #: | SEX: | PRIMARY CARE PHYSICIAN: |
| PATIENT PHONE #: | | PREADMIT DATE: | PREADMIT TIME: |
| SURGERY DATE: | SURGERY TIME: | SURGERY DURATION: | |

**PATIENT HISTORY (ABNORMAL FINDINGS MAY INDICATE NEED FOR MEDICAL/CARDIAC CLEARANCE)**

| HISTORY OF: | ☑ | MEDICATIONS | ☑ |
|---|---|---|---|
| High Blood Pressure | | Blood Pressure | |
| Heart Attack/Murmur | | Heart Medicines | |
| Stroke | | Diuretic | |
| Diabetes | | Blood Thinners | |
| Asthma/Emphysema | | Insulin | |
| Sleep Apnea | | MAO Inhibitors | |
| Recent Hospitalization | Date: | Other | |

**PERIOPERATIVE RISK ASSESSMENT (COMPLETE PRIOR TO PREADMISSION TESTING APPOINTMENT)**

| DATE CLEARED: | | | | PHYSICIAN: | | | | |
|---|---|---|---|---|---|---|---|---|
| HEIGHT | | WEIGHT | | BLOOD PRESSURE | | LMP | | DUE DATE |
| ALLERGIES | | | | | | | | |

**CLINICAL INFORMATION**

| | | |
|---|---|---|
| 1 | PATIENT TYPE ❑ OPS ❑ IP STATUS ❑ ELECTIVE ❑ URGENT | URGENT JUSTIFICATION: |
| 2 | DIAGNOSIS CODES (ICD10)− SURGERY AND TESTING | DIAGNOSIS DESCRIPTION |
| 3 | PROCEDURE CODES | PROCEDURE DESCRIPTION |
| 4 | NERVE BLOCK: ❑ 64450− Popliteal ❑ 64415− Interscalene ❑ 64447− Femoral ❑ 76942−US Guidance for Block ❑ Other: | |
| 5 | SPECIAL EQUIPMENT INSTRUCTIONS:<br>❑ C− ARM<br>❑ X − RAY _____<br>❑ PATHOLOGY<br>❑ IMPLANTS _____<br>−VENDOR _____<br>−Rep Phone# | ADDITIONAL SPECIAL INSTRUCTIONS:<br>❑ Post OP Bed Required<br>❑ Post OP Critical Care Bed Required<br>❑ Other: _____ |

**INSURANCE CLEARANCE (Fax Ins cards, authorizations, referrals to 389−2165) − LIST primary and secondary plans**

| INSURANCE | POLICY NUMBER | | INSURANCE STATUS CHECK: |
|---|---|---|---|
| PRECERT STATUS<br>❑ APPROVED<br>❑ DENIED<br>❑ PENDING | AUTH/REF # | UNITS: | ❑ Insurance is in network for hospital and surgeon<br>❑ Benefits cover scheduled procedure<br>❑ Insurance reviewed for referral requirements<br>❑ Addendum E reviewed for IP only procedures<br>❑ Request date within 30 days of request for Medicaid |

EFFECTIVE FOR DOS 10/1/2015, ONLY ICD 10 CODES WILL BE ACCEPTED.