

Office Scheduler: _____ Form Fax # _____

Admission Type: ☐ New Request ☐ CHANGE REQUEST

☐ **Same Day** - It is Medically necessary for this patient to have this procedure today ____/____/____;
 the Moreland Surgery Center is suitable for this procedure. _____ (Physician Signature Required)

Request Date: _____ **Time:** _____

Last Name: _____ **First Name:** _____ **MI** _____

Address: _____ **City:** _____ **State:** _____

Contact Phone: _____ **Alt Phone:** _____

D.O.B: _____ **Ht:** _____ **Wt:** _____ (BMI less than 45) **Drug Allergies:** _____

Patient Email: _____

(Email used for patient survey and internal patient registration purposes only)

 Patient notified of Online Pre-Registration ☐ **Interpreter Services needed:** ☐
Surgeon: _____ **H&P Physician:** _____ **PCP:** _____

Authorization # _____ **Duration:** _____

Procedure Consent: _____ **Primary CPT Code** _____

PreOp Diagnosis _____ **Primary DX Code** _____

Anesthesia: ☐ GENERAL ☐ MAC ☐ IV SED ☐ LOCAL
☐ Aspirin Last Dose on: _____ ☐ Coumadin Last Dose: _____ ☐ Plavix Last Dose

Pre-Admission Testing Will be done at:

<input type="checkbox"/> COVID -19 TEST [lab #4551]	<input type="checkbox"/> CXR (PA & LAT)	<input type="checkbox"/> Hemogram	<input type="checkbox"/> UA
<input type="checkbox"/> CBC	<input type="checkbox"/> EKG	<input type="checkbox"/> None	<input type="checkbox"/> Urology Standing Order
<input type="checkbox"/> CMP	<input type="checkbox"/> Follow Anesth Protocol	<input type="checkbox"/> Pro-time/INR	<input type="checkbox"/> Other _____
<input type="checkbox"/> Basic Metabolic Panel			

Day Of Surgery Testing

<input type="checkbox"/> Finger-Stick FBS	<input type="checkbox"/> PT/INR	<input type="checkbox"/> Other _____
<input type="checkbox"/> KUB	<input type="checkbox"/> Urine Pregnancy	

Pre-Op Antibiotics

<input type="checkbox"/> Cefazolin per weight-based dosing strategy	<input type="checkbox"/> Cipro 500mg upon arrival p.o.	<input type="checkbox"/> CeFOXitin per weight-based dosing str
<input type="checkbox"/> Clindamycin ____ 600mg IV ____ 900mg IV	<input type="checkbox"/> Ciporfloxacin 400 mg IV	<input type="checkbox"/> Gentamycin 240mg IV
<input type="checkbox"/> Other _____	<input type="checkbox"/> Rocephi <input type="checkbox"/> 1g	

Other Medication & Items

<input type="checkbox"/> Ketorolac 30mg IV	<input type="checkbox"/> Oxymetazolin Nasal Spray, Two Sprays each Nostril _____
<input type="checkbox"/> Dexamethasone ____ mg IV	<input type="checkbox"/> Fleets Enema x ____ on arrival
<input type="checkbox"/> Sequential Circulatory Device	<input type="checkbox"/> Other _____

Additional Needs: _____

Order Date: ____/____/____ **Order Time:** _____ **Order Signature:** _____

Confirmation: _____

Scheduled Date: ____/____/____ **Scheduled Time:** _____ **Scheduler:** _____