

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** _____ **Sex:** M F

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

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** _____

_____ **Primary DX Code** _____

PreOp Diagnosis _____

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

Pre-Admission Testing Will be done at: _____

Basic Metabolic Panel CXR (PA & LAT) Hemogram UA
 CBC EKG None Urology Standing Orders
 CMP Follow Anesth Protocol Pro-time/INR Other _____

Day Of Surgery Testing

Finger-Stick FBS PT/INR Other _____
 KUB Urine Pregnancy

Pre-Op Antibiotics

Cefazolin per weight-based dosing strategy Cipro 500mg upon arrival p.o. CeFOXitin per weight-based dosing strategy
 Clindamycin ____ 600mg IV ____ 900mg IV Ciporfloxacin 400 mg IV Gentamycin 240mg IV Rocephin 1gram IV
 Other _____

Other Medication & Items

Ketorolac 30mg IV Oxymetazolin Nasal Spray, Two Sprays each Nostril _____
 Dexamethasone ____mg IV Fleets Enema x ____ on arrival
 Sequential Circulatory Device Other _____

Additional Needs: _____

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

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