ISLAND HOSPITAL

All ☐ must be checked to initiate order. If order not indicated draw a line through it.

Patient Name:	Date of Birth:	Phone number:
Admit to: ☐ Inpatient ☐ Outpatient with bed (option includes discharge to home) ☐ Observation	Date/Time of Surgery:	Check in time:
Surgeon:	Primary Care Provider:	
Diagnosis/ Code:	Insurance:	
Surgical Procedure Anticipated / Code:		
Code Status: ☐ Full code ☐ DNR ☐ Other:		
Allergies: ☐ NKDA ☐ See provided list ☐ List allergies:		

1.	☐ **No pre-operative orders (go to number 4)**	
2.	**The following tests have been ordered:**	
	Please come to the Hospital to have any Laboratory, X-Ray and EKG tests. **If tests obtained at another facility: Please fax results to Island Hospital Surgery Department at 360 299-1382.**	
	☐ CBC ☐ PT/INR ☐ PTT ☐ K+ ☐ H&H ☐ Hemoglobin A1c	☐ HEMOGRAM ☐ GLUCOSE ☐ CREATININE ☐ COMP.METAB.PANEL ☐ BASIC METAB.PANEL
	☐ ELECTROLYTES ☐ HEPATIC FUNCTION ☐ TYPE AND SCREEN ☐ TYPE AND CROSS _____ UNITS ☐ UA SCREEN ☐ UA COMPLETE WITH CULTURE	
	☐ EKG ☐ CHEST XRAY	
	Test specific diagnosis:	
3.	☐ Other tests:	
4.	**Day of Surgery Orders:** ☐ No Surgery Orders ☐ SCDs ☐ Compression Stockings ☐ Foley Catheter in OR	☐ CBG (Accu-check) ☐ INR ☐ Wash operative site with antiseptic soap. ☐ Endoscopy protocol
5.	Pre-operative antibiotic: ☐ None needed ☐ Antibiotic:	
6.	Further Instruction: ☐ None	
7.	Post-operative appointment:	

_____ _____

Healthcare Provider Signature Date/Time