

Case #	
Scheduled:	

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

Admit to:	Patient Name:			Date of Birth:		Phone number:				
Date/Time of Surgery: Diagnosis/ Code: Insurance: Diagnosis/ Code:	□ Ir □ C	npatient Outpatient with bed ption includes discharge to home)	Surgeon:			Primary Care Provider:				
Surgical Procedure Anticipated / Code: Code Status:						Check in Time:				
Code Status:	Diagnosis/ Code:				Insurance:					
Allergies: NKDA See provided list List allergies: 1. No pre-operative orders (go to number 4) 2. The following tests have been ordered:	Surgical Procedure Anticipated / Code:									
1.	Code Status: Full code DNR Other:									
2. The following tests have been ordered: Please come to the Hospital to have any Laboratory, X-Ray and EKG tests at least 3-5 days before your scheduled surgery. If tests obtained at another facility: Please fax results to Island Hospital Surgery Department at 360-299-1382. □ CBC □ HEMOGRAM □ ELECTROLYTES □ PT/INR □ GLUCOSE □ HEPATIC FUNCTION □ PTT □ CREATININE □ TYPE AND SCREEN □ HAWAND SCREEN □ UNITS □ BASIC METAB.PANEL □ TYPE AND CROSS □ UNITS □ BASIC METAB.PANEL □ UA SCREEN □ UA COMPLETE WITH CULTURE □ EKG □ CHEST XRAY □ CBG (blood glucose - fingerstick) □ No Surgery Orders □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ SCDs □ CBG (blood glucose - fingerstick) □ INR □ CBG (blood glucose - fingerstick) □ ING □ C	Allergies	Allergies: NKDA See provided list List allergies:								
Please come to the Hospital to have any Laboratory, X-Ray and EKG tests at least 3-5 days before your scheduled surgery. If tests obtained at another facility: Please fax results to Island Hospital Surgery Department at 360-299-1382. CBC		☐ No pre-operative orders (go to number 4)								
your scheduled surgery. If tests obtained at another facility: Please fax results to Island Hospital Surgery Department at 360-299-1382. GBC	2.	The following tests ha	ve been order	ed:						
PT/INR		your scheduled surgery. If tests obtained at another facility: Please fax results to Island Hospital								
3. Other tests: 4. Day of Surgery Orders:		PT/INR PTT K+ H&H	GLUCOSE CREATINII COMP.ME BASIC ME UA SCREE UA COMPI	: NE TAB.PANEL TAB.PANEL EN	HEP/ TYPE - TYPE	ATIC FUNCTION E AND SCREEN	_UNITS			
4. Day of Surgery Orders:		l est specific diagnosi	S:							
□ No Surgery Orders □ INR □ SCDs □ Ensure patient has washed operative site with antiseptic soap. If not, wash operative site with antiseptic wipes (unless allergic). □ Foley Catheter in OR □ Endoscopy protocol 5. Pre-operative antibiotic: □ None needed □ Antibiotic: □ Antibiotic: 6. Further Instruction: □ None □ Patient has pacemaker/internal defibrillator	3.	☐ Other tests:								
□ None needed □ Antibiotic: 6. Further Instruction: □ None □ Patient has pacemaker/internal defibrillator	4.	☐ No Surgery Orders ☐ SCDs ☐ Compression Hose	Surgery Orders INR Ensure patient has washed operative site with antiseptic soap. If not, wash operative site with antiseptic wipes (unless allergic).							
☐ Patient has pacemaker/internal defibrillator	5.	☐ None needed								
	6.	Further Instruction:	None							
7. Post-operative appointment:		☐ Patient has pacemaker/internal defibrillator								
	7.									

Healthcare Provider Signature

Date/Time SO4865

Fax completed form to 360-299-1382