BroMenn

RAPID

Pre-Admission Testing and Surgery Scheduling Form

Patient Name:_____/_____/____
Last *First* *MI*

Male/Female *Circle one*

Date of Birth: _____/_____/_____
Month *Day* *Year*

Pre-authorization Number:

Home Phone:

Cell Phone:

Work Phone:

Requested Surgery Date:____/____/____

Scheduled Surgery Date: ____/____/____

Requested Surgery Time:_____ **AM PM**

Scheduled Surgery Time: _____ **AM PM**

Estimated Length of Case _____

Pretesting Date: _____/_____/_____

Pretesting Time: _____ **AM PM**

Surgeon: _____

Assistant: Y/N _____

Admission Type:
☐ Outpatient
☐ Inpatient Admission: Day of Surgery

Anesthesia Type: *(circle)* Local Local/Sedation MAC (Monitored Anesthesia Care) Epidural Spinal Spinal Narcotic General Nerve Block: _____

Anesthesia Group: (*circle one*) MCA AC

Allergies: ☐ **Latex**

H&P: ☐ Will dictate ☐ Will do on arrival ☐ Will fax to BroMenn

Pre-Op Diagnosis:

Primary Diagnosis Code:

Secondary Diagnosis Codes:

Consent to Read: _____

Implant or Equipment Requested:_____

Vendor: Type:

☐ **Vendor Notified**

☐ **Follow Routine Standing Orders for Procedure**

Pre-Admission Testing Physician Orders

☐ CBC	☐ BMP	☐ Urine Pregnancy
☐ Hemogram	☐ CMP	☐ Serum Pregnancy
☐ Hgb	☐ Amylase	☐ Beta Pregnancy
☐ Hct	☐ Lipase	☐ Autologus _____ units
☐ UA	☐ Sed Rate	☐ Clot to Hold
☐ Urine Culture	☐ TSH	☐ Type and Screen
☐ PFA	☐ HIV	☐ Type & Cross _____units
☐ PT	☐ CA 125	☐ Chest X Ray
☐ PTT		☐ EKG: Dr. to read:_____

Previous EKG:
When:_____
Where:_____

Patient Conditions:
☐ MRSA ☐ Diabetes
☐ Hypertension ☐ Coumadin
☐ Malignant Hyperthermia

Additional Tests, Pre-medications or special instructions:

_____/_____
Physician Signature Date

Please do not mark this area until you receive this form 48 hours before day of surgery.

☐ **CASE CONFIRMED** **OFFICE STAFF CONTACT** _____/_____
Signature Date

FAX COMPLETED FORM TO: 268-3507

Thank You for choosing BroMenn Regional Medical Center

11/08

PROCEDURE