Booking Request / Pre-Admit Orders

PHONE NUMBER: 561-784-3128 eFAX NUMBER: 561-273-0120

Patient Name:	**Surgery Date:** **Time:**
Procedure:	
ICD10:	
CPT:	
Surgeon:	

Sex: ☐ *M* ☐ *F* *DOB:* _____ *SS#:* _____

Address: _____

City: _____ *ST:* _____ *Zip:* _____

Interpreter needed: _____

Insurance 1: _____

Policy 1 #: _____

Insurance 2: _____

Policy 2 #: _____

PCP Name: _____

SPECIAL REQUEST:

☐ *Laser* ☐ *Gamma Probe* ☐ *Cell Saver* ☐ *APC*

☐ *C-Arm* ☐ *Mini C-Arm* ☐ *Stealth*

☐ *Myosure/Aquilex* ☐ *Novasure*

☐ *Neuro Monitoring*

☐ *Implants:* _____

☐ *Bone/Tissue Graft:* _____

☐ *Specialty Instruments:* _____

Vendor Name: _____

Vendor Number: _____

Email Address: _____

Pt. Phone #1 (mobile): _____

Pt. Phone #2: _____

☐ *Inpatient* ☐ *Outpatient*

Expected Level of Anesthesia:

☐ *General* ☐ *MAC* ☐ *Regional* ☐ *Local* ☐ *Block*

Pre-Op Date/Time: _____

PRE-ADMIT ORDERS:

Pre-Op eFax #: 561-273-0120 Telephone #: 561-784-3119

☒ *Enhanced Surgical Recovery if Appropriate*

☒ *MRSA/MSSA Screening and Decolonization Protocol*
(Required for patients with planned implants)

☒ *Initiate Pre-Operative Anesthesia Guidelines*

☐ *COVID test*

☐ *Request Hospitalist to Consult/Follow Up Post-Op Admissions*

Provider Specific Pre-Admit Orders:

(Anesthesia Guidelines will Order Appropriate Screening Test)

☐ *CBC w/auto* ☐ *CBC w/no diff* ☐ *UA C&S*

☐ *Comp Metabolic* ☐ *Basic Metabolic* ☐ *Chest X-Ray*

☐ *PTT* ☐ *PT/INR*

☐ *Type & Screen* ☐ *Type & Cross, # of units* _____

☐ *EKG: Indication* _____

☐ *Medical Clearance to be done at HCA FL PWH*

☐ *Other:* _____

OPTIMIZATION NEEDED:

☐ *Medical* ☐ *Cardiac* ☐ *Other as Needed:* _____

Physician/PA
Signature: _____ **Date:** _____ **Time:** _____

HCA Florida
Palms West Hospital

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Patient Identification / Label