TriStar Skyline MEDICAL CENTER

Physician's Orders – Surgery / Interventional Procedures (For Pre-op, Inpatient, and Outpatient Use)

Revised: 8/30/12

Central Scheduling:
Office: 615-769-7226
Fax: 1-866-401-6442

Patient Name: _____ Physician: _____
Patient SS#:_____ Pre-op Appt Date: _____ Time: _____
Date of Birth: _____ Age: _____ Precert / Authorization #: _____

Scheduled Procedure Date: _____ Time: _____ Estimated Procedure Time: _____

Diagnosis: _____

□ Patient on Anticoagulants (Coumadin, Aspirin, etc.)
□ Other Pertinent Patient Information / Communicable Diseases: - _____

LAB	RADIOLOGY	ULTRASOUND
□ CBC □ BMP □ PT □ PTT □ Creatinine □ Urinalysis □ Urine Culture if indicated by UA □ HCG – Pregnancy Test □ Type and Screen □ Type and Crossmatch _____ Units □ _____ □ _____ □ _____	□ Chest PA/LAT □ Abdomen KUB □ _____ □ _____ □ _____ **CT MRI** □ _____ □ _____ □ _____ **NUCLEAR MEDICINE** □ Hepatobiliary Scan □ Lymphoseintography □ _____	□ Abdomen _____ Complete _____ Limited: _____ □ Gallbladder □ Needle Localization w/Ultrasound □ Doppler □ Arterial □ Upper □ Lower □ TCD □ Bilateral □ Carotid □ Venous □ Right □ Left □ Upper □ Lower □ _____ □ _____ □ _____

OTHER	
□ EKG □ 2D Echocardiogram □ Mammography □ Breast Stereotactic □ Needle Localization w/mammo □ _____ □ _____	Antibiotics: □ N/A _____ Antibiotics per Protocol: □ Yes □ No Pre-op Medications: □ N/A _____ NPO Status: □ NPO after MN □ Other: _____ □ Anesthesia Consult Requested Anesthesia Type: _____ □ SCD □ TED Allergies: _____ _____

PRE-OPERATIVE / PRE-PROCEDURAL ORDERS ***(Must be completed)***

Permit For: _____
_____

□ Initiate Anesthesia Protocol
Other Orders: _____
_____
_____
_____
_____
_____
_____
_____

MD Signature: _____ **Date**: _____ **Time**: _____