Booking & Pre-Op Surgery Orders v13 Beaufort Memorial HOSPITAL

Booking Information

Please Print or Type. Do Not Use Abbreviations.

Main OR [☐ Inpatient (IP) ☐ Observation (OPPO) ☐ Outpatient (OP)] ☐ **BMSC**

Date of Surgery ________________ Allotment _______ Time __________ Surgeon ______________________________

Last Name _______________________________ First __________________________ MI ________ ☐ Male ☐ Female

Address ____ City, State, zip ________________________________

Phone # (Home) __________________ (Work) ___________________ DOB ____________ H# _______________________

Primary Insurance _____________________________________ Policy/Group # _________________________________

Secondary Insurance ____________________________________ Policy/Group # ________________________________

ICD10 (REQUIRED) ___________________________________ CPT Code(s)(REQUIRED) ____________________________

Office Scheduler Name ________________________________ Date/Time ___________________

Office Scheduler Verify and Print Procedure ____

____

Pre-Op ☐ Visit ________________________ ☐ Phone Call ☐ Anesthesia Consult ☐ PAC

Covid vaccination up to date (circle) YES NO

Orders

Procedure ____

____

____

Diagnosis ____

Special Equipment ____

Allergies Update allergies w/ reaction ____

Labs and Diagnostics

- ☐ CBC w/ Auto Differentiation
- ☐ CBC-O (Collect extra SST) for blood conservation
- ☐ Prothrombin Time – PT/INR
- ☐ Partial Thromboplastin Time - PTT
- ☐ Metabolic Panel (Basic) – BMP
- ☐ Metabolic Panel (Complete) – CMP
- ☐ Pregnancy Test (Urine)
- ☐ Urinalysis
- ☐ Culture, Urine
- ☐ Blood Type
- ☐ Type and Screen
- ☐ Glycated Hemoglobin (A1c)
- ☐ Chest PA & Lateral - Reason for exam – Pre-op
- ☐ Electrocardiogram - Reason for exam – Pre-op
- ☐ MRSA Culture Screen (Nasal Swab)

Other

☐ Obtain Consent for Blood Transfusion ☐ Obtain Consent for Sterilization

☐ SCD Left Calf ☐ SCD Right Calf ☐ SCD Left Foot ☐ SCD Right Foot

Medications Please enter drug and dose.

☐ Antibiotics ____________________________________ IVPB on call to OR

☐ Vancomycin ________ grams IVPB on call to OR (*if Cephalosporin allergic or MRSA positive)*

☐ Other Medications: ____

Additional Orders ____

____

Physician's Signature ___________________________

Date ______________ Time __________