MEMORIAL HERMANN Surgical Hospital First Colony

☐ **Revised Order**

Surgical Scheduling Information Sheet and Order FAX TO 281-243-1044

Procedure date:____/____/_____Time:_____ Length of procedure:_____hr

Admit Status: ☐ Outpatient ☐ Inpatient

Surgeon:_____Assistant:_____

CPT Code(s): _____ DX/ICD-10: _____

Procedure(s) / consent for: _____

_____

☐ Bilateral _____

☐ Left _____

☐ Right _____

☐ Levels _____

Supplies/System/Equipment requests: _____

_____

Check all that apply:

☐ Latex allergy
☐ MRSA/MDRO
☐ VRE
☐ Cell saver
☐ Translator
☐ Infection
☐ Revision/Return

Rep. notified: ☐ Yes ☐ No ☐ N/A

Anesthesia type: ☐ General ☐ Local ☐ Monitored anesthesia care ☐ Bier Block ☐ Spinal/Epidural ☐ Anesthesia choice

History of surgery or hospital admission within the last 30 days? : ☐ Yes ☐ No History of recent infection? ☐ Yes ☐ No

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Patient name:_____ ☐ Male ☐ Female
(First) (MI) (Last)

DOB:____/____/_____ Social Security #_____-_____-_____ Email: _____

Home address: _____

Phone# : _____

Insurance carrier:_____Subscriber Name: _____

Work or Accident Related Injury: ☐ Yes ☐ No

(Include copy of patient's insurance card and driver's license.)

Patient Height:_____ Weight:_____ BMI:_____

Allergies/Adverse reactions: _____

Primary Physician:_____ Phone: _____

Cardiologist:_____ Phone: _____

Patient Has: ☐ Pacemaker ☐ Defibrillator If so please include a copy of the patients Cardiac Rhythm Management Devices (CRMD) card when scheduling. For patient safety we need the make and model so we can notify the representative to be here during the procedure.

PLEASE FAX ALL AVAILABLE Clearances, H&Ps, LAB RESULTS/EKG/RADIOLOGY REPORTS to 281-243-1051

PCP Name: _____

PRE-OP TESTING ☐ Completed at PCP/Surgeon Office

☐ Anesthesia Protocol
☐ EKG
☐ Chest X-ray
☐ CBC w/diff
☐ BMP
☐ U/A ☐ **Urine C&S**
☐ CMP
☐ PT/INR
☐ PTT
☐ Other:_____
☐ Type & cross____unit

☐ Medical Clearance ☐ Cardiac Clearance ☐ Other Clearance:_____

PHYSICIAN SIGNATURE:_____**DATE:**_____**TIME:** _____

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Patient name: _____
First *MI* *Last*

DAY OF SURGERY PRE-OPERATIVELY ANTIBIOTIC ORDERS: ☐ **None**

_____ cefazolin (ANCEF®) 2 Gm IVPB once within 1 hr prior to surgical incision if Pt. wt less than 120 Kg. **Administer only if Pt. is not allergic to penicillin/cephalosporin drug family.**

_____ cefazolin (ANCEF®) 3 Gm IVPB once within 1 hr prior to surgical incision if Pt. wt greater than 120 Kg. **Administer only if Pt is not allergic to penicillin/cephalosporin drug family.**

_____ clindamycin phosphate 900 mg IVPB once within 1 hr prior to surgical incision. **If patient allergic to penicillin/cephalosporin drug family.**

_____ vancomycin hydrochloride 15 mg/Kg, IVPB once within 2 hrs prior to surgical incision, maximum dose of 2000 mg or 2 grams

Reason for vancomycin: MUST HAVE REASON FOR VANCOMYCIN

_____Beta-lactam (penicillin or cephalosporin) allergy _____ Documented MRSA colonization
_____Recent Hospitalization or procedure _____ Facility high rate of MRSA
_____Active Infection _____ Other:_____

_____ OTHER ANTIBIOTIC:_____

BETA BLOCKERS: Instruct patient to take beta blockers as prescribed day of surgery.
ACE INHIBITORS: HOLD 24 hours prior to surgery.

Blood thinners/NSAIDS/ASA: Please give your patient instructions as to when to stop blood thinners/NSAIDS/ASA prior to their procedure. This includes supplements such as Glucosamine, Fish Oil, Vitamin E.

PHYSICIAN SIGNATURE:_____DATE:_____TIME: _____

SURGERY SCHEDULING/PHYSICIAN ORDER

Surgical Scheduling Information Sheet and Order FAX TO 281-243-1044

FAX ALL, H&P, CONSENTS AND TESTING RESULTS WITH THIS FORM to 281-243-1051