



fraserhealth

SURGICAL BOOKING FORM



ORPO100032G

Rev: Oct. 2013

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ARH <input type="checkbox"/> BH <input type="checkbox"/> CGH <input type="checkbox"/> DH <input type="checkbox"/> ERH <input type="checkbox"/> JPOCSC <input type="checkbox"/> LMH <input type="checkbox"/> PAH <input type="checkbox"/> RCH <input type="checkbox"/> RMH <input type="checkbox"/> SMH <input type="checkbox"/>														
PATIENT SURNAME (legal)					FIRST NAME (legal)			OTHER NAMES		DOB (d/m/yyyy)		AGE	SEX M <input type="checkbox"/> F <input type="checkbox"/>	
ADDRESS						PHONE Res				Cell				
CITY			PROVINCE			POSTAL CODE			Bus		Ext			
FAMILY PHYSICIAN					REFERRING PHYSICIAN (if not family)									
SURGEON / PHYSICIAN Dr					ASSISTANT YES <input type="checkbox"/> NO <input type="checkbox"/>					CARE CARD#				
BILLING INFO:														
MSP <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER <input type="checkbox"/> IF NOT MSP SPECIFY: PLAN _____													# _____	
DATE OF REFERRAL (d/m/yyyy)				DATE OF FIRST CONSULT (d/m/yyyy)				SURGERY DECISION DATE (d/m/yyyy)						
OR DATE (d/m/yyyy)				ADMISSION DATE (d/m/yyyy)										
PRIORITY 1A <input type="checkbox"/> 1B <input type="checkbox"/> 1C <input type="checkbox"/> 2A <input type="checkbox"/> 2B <input type="checkbox"/> 3A <input type="checkbox"/>						ADMISSION TYPE SDC <input type="checkbox"/> SDA <input type="checkbox"/> INPT <input type="checkbox"/> ABS <input type="checkbox"/>								
STAT <8 hr <24 hr <72 hr <3 wk >3 wks						Will Require: ICU <input type="checkbox"/> Potential MONITOR BED <input type="checkbox"/>								
PROCEDURE(S) - PLEASE LIST THE PRIMARY PROCEDURE FIRST. (It is the most invasive and resource intensive procedure)														
1) SIDE _____		PROC. _____												
2) SIDE _____		PROC. _____												
3) SIDE _____		PROC. _____												
4) SIDE _____		PROC. _____												
DIAGNOSIS CODE: _____						CJRR Revision Code: _____			BMI if > 40 _____			ONCOLOGY/CANCER:		
DIAGNOSIS (OTHER): _____						Skin to skin			Not Suspected <input type="checkbox"/>					
						(Minutes) _____			Suspected <input type="checkbox"/>			Proven <input type="checkbox"/>		
OR NEEDS:					LYMPHOMA PROTOCOL <input type="checkbox"/>		FROZEN SECTION <input type="checkbox"/>		TISSUE REQUIRED <input type="checkbox"/>					
(List other needs in Comments)					C-ARM REQUIRED <input type="checkbox"/>		X-RAY in OR <input type="checkbox"/>							
SPECIAL EQUIPMENT/IMPLANTS: _____														
PATIENT ALERTS: PACEMAKER <input type="checkbox"/> MH HISTORY <input type="checkbox"/> Type 2 DM <input type="checkbox"/> Type 1 DM <input type="checkbox"/> INFECTION CONTROL <input type="checkbox"/>														
LATEX ALLERGY <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> INTERPRETER REQ'D <input type="checkbox"/> IF YES, LANGUAGE: _____														
COMMENTS: _____														
ANESTHETIC TYPE: GEN. <input type="checkbox"/> LOC. <input type="checkbox"/> REG. <input type="checkbox"/> SP. <input type="checkbox"/> EPID. <input type="checkbox"/> IV SED. <input type="checkbox"/> TOPICAL <input type="checkbox"/>														
UNAVAILABLE PERIOD INFO:														
UNAV. START DATE (d/m/yyyy)					UNAV. END DATE (d/m/yyyy)					UNAV. REASON _____				
OR BOOKING FORM RECEIVED (d/m/yyyy):										UNIT #				

Print Shop # 357136



SURGICAL PRE-OPERATIVE TEST ORDER



ORPO100033G

REV: Oct. 2013

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PATIENT SURNAME (legal)	FIRST NAME (legal)	Other names	DOB (d/m/yyyy)	CARE CARD#
PRIMARY PROCEDURE			SURGEON / PHYSICIAN Dr.	

Not Applicable For This Patient
 Non FH Results Attached
 Refer to Previous FH Results

<p><u>PREOPERATIVE LAB ORDERS</u></p> <table border="0"> <tr> <td><input type="checkbox"/> Hematology profile (CBC)</td> <td><input type="checkbox"/> Urine Pregnancy</td> </tr> <tr> <td><input type="checkbox"/> INR</td> <td><input type="checkbox"/> Fasting Glucose</td> </tr> <tr> <td><input type="checkbox"/> PTT</td> <td><input type="checkbox"/> Random Glucose</td> </tr> <tr> <td><input type="checkbox"/> RH (D) Typing</td> <td><input type="checkbox"/> Sodium</td> </tr> <tr> <td><input type="checkbox"/> Group & Screen</td> <td><input type="checkbox"/> Potassium</td> </tr> <tr> <td><input type="checkbox"/> Cross Match # units _____</td> <td><input type="checkbox"/> Creatinine</td> </tr> <tr> <td><input type="checkbox"/> Autologous Donation _____</td> <td><input type="checkbox"/> Albumin</td> </tr> <tr> <td><input type="checkbox"/> Other Blood Products</td> <td></td> </tr> </table> <p><u>Other Orders:</u> _____</p>	<input type="checkbox"/> Hematology profile (CBC)	<input type="checkbox"/> Urine Pregnancy	<input type="checkbox"/> INR	<input type="checkbox"/> Fasting Glucose	<input type="checkbox"/> PTT	<input type="checkbox"/> Random Glucose	<input type="checkbox"/> RH (D) Typing	<input type="checkbox"/> Sodium	<input type="checkbox"/> Group & Screen	<input type="checkbox"/> Potassium	<input type="checkbox"/> Cross Match # units _____	<input type="checkbox"/> Creatinine	<input type="checkbox"/> Autologous Donation _____	<input type="checkbox"/> Albumin	<input type="checkbox"/> Other Blood Products		<p>OR Date (d/m/yyyy)</p> <hr/> <p><u>ALLERGIES:</u> _____</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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<input type="checkbox"/> Autologous Donation _____	<input type="checkbox"/> Albumin																
<input type="checkbox"/> Other Blood Products																	
<p><u>PREOPERATIVE MEDICAL IMAGING ORDERS</u></p> <p><input type="checkbox"/> Chest X-Ray</p> <p><input type="checkbox"/> Other: _____</p> <hr/>	<p><u>CARDIOLOGY ORDERS:</u> <input type="checkbox"/> ECG</p> <p><u>PRE-OP ANTIBIOTICS:</u> _____</p> <hr/> <p><input type="checkbox"/> See Doctor's Orders</p>																
<p><u>OTHER ORDERS</u></p> <p><input checked="" type="checkbox"/> Anaesthesia Consult as Required</p> <p><input type="checkbox"/> Social Work Required <input type="checkbox"/> Home Care Required</p> <p><u>DAY OF SURGERY ORDERS</u></p> <p><input type="checkbox"/> Fasting Glucose</p> <p><input type="checkbox"/> Accucheck</p> <p><input type="checkbox"/> INR</p>	<p><u>OTHER PRE-OPERATIVE ORDERS:</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>																

PHYSICIAN SIGNATURE: _____ Date (d/m/yyyy): _____

PROTOCOL FOR: PRE-OPERATIVE TEST ORDER

1. The use of routine pre-operative testing should be discontinued.
2. Testing should be performed only when indicated by the patient's history or physical examination or by the specific procedure being performed or the type of anesthesia being used.
3. Patients who have **had** one or more of the following tests recently at a DAP (Diagnostic Accreditation Program) accredited BC facility should NOT be retested if the results are available and within normal limits, unless their clinical status has changed significantly: **Except for Implantable Cardiac Electrical Device procedures - please refer to the Regional Pre-Printed Orders (Pre-Procedure Step 1 of 2):**
 - Laboratory tests and ECGs performed within the previous 3 months or
 - Chest x-rays performed within the previous 6 months.

Pre-operative test to be considered for common clinical problems and symptoms:

Patient Category	Test
Neonates and infants up to one year	Hemoglobin
Women who cannot rule out pregnancy	Urine pregnancy test
Women with hypermenorrhea	Hemoglobin
Pregnant women undergoing procedures where they may be exposed to fetal red blood cell antigens	Rh(D) typing
Cardiovascular disease/risk factors e.g. diabetics > 40 yrs of age patients > 60 yrs of age subarachnoid or intracranial hemorrhage, cerebrovascular accident	ECG
Head trauma	EEG
Pulmonary disease	Chest x-ray
Malignancies with potential metastases	CBC, chest x-ray Note: Hematological malignancies will also require CBC and platelets.
Hepatic disease	INR, CBC, platelets, AST, Alk Phos, bilirubin
Renal disease	Na, K, creatinine/urea, hemoglobin
Diabetes	Na, K, creatinine/urea, glucose Note: ECG if age >40yrs.
Diuretic use	Na, K, creatinine/urea
Coumadin use	Hemoglobin, INR
Patients requiring Group and Screen	Test within 42 days of surgery
Patients requiring other blood products eg: platelets, factor concentrates	Notify Transfusion Medicine Laboratory of requirements at least 2 days prior to surgery.