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SURGICAL BOOKING FORM

ORPO100032G Rev: Oct. 2013

ARH ☐ BH ☐ CGH ☐ DH ☐ ERH ☐ JPOCSC ☐ LMH ☐ PAH ☐ RCH ☐ RMH ☐ SMH ☐

PATIENT SURNAME (legal)	FIRST NAME (legal)	OTHER NAMES	DOB (d/m/yyyy)	AGE	SEX M ☐ F ☐

ADDRESS			**PHONE** Res	Cell
CITY	PROVINCE	POSTAL CODE	Bus	Ext

FAMILY PHYSICIAN	REFERRING PHYSICIAN (if not family)	
SURGEON / PHYSICIAN **Dr**	**ASSISTANT** YES ☐ NO ☐	**CARE CARD#**

BILLING INFO:
MSP ☐ PRIVATE ☐ OTHER ☐ 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 ☐ STAT 1B ☐ <8 hr 1C ☐ <24 hr 2A ☐ <72 hr 2B ☐ <3 wk 3A ☐ >3 wks

ADMISSION TYPE SDC ☐ SDA ☐ INPT ☐ ABS ☐
Will Require: ICU ☐ Potential MONITOR BED ☐

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:
DIAGNOSIS (OTHER): _____

BMI if > 40 _____
Skin to skin (Minutes) _____

ONCOLOGY/CANCER:
Not Suspected ☐
Suspected ☐ Proven ☐

OR NEEDS: (List other needs in Comments)
LYMPHOMA PROTOCOL ☐ FROZEN SECTION ☐ TISSUE REQUIRED ☐
C-ARM REQUIRED ☐ X-RAY in OR ☐

SPECIAL EQUIPMENT/IMPLANTS: _____

PATIENT ALERTS: PACEMAKER ☐ MH HISTORY ☐ Type 2 DM ☐ Type 1 DM ☐ INFECTION CONTROL ☐
LATEX ALLERGY ☐ SLEEP APNEA ☐ INTERPRETER REQ'D ☐ IF YES, LANGUAGE: _____

COMMENTS: _____

ANESTHETIC TYPE: GEN. ☐ LOC. ☐ REG. ☐ SP. ☐ EPID. ☐ IV SED. ☐ TOPICAL ☐

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

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SURGICAL PRE-OPERATIVE TEST ORDER

ORPO100033G REV: Oct. 2013 Page: 1 of 1

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

PREOPERATIVE LAB ORDERS

☐ Hematology profile (CBC)
☐ INR
☐ PTT
☐ RH (D) Typing
☐ Group & Screen
☐ Cross Match # units_____
☐ Autologous Donation_____
☐ Other Blood Products
☐ Urine Pregnancy
☐ Fasting Glucose
☐ Random Glucose
☐ Sodium
☐ Potassium
☐ Creatinine
☐ Albumin

Other Orders: _____

OR Date (d/m/yyyy)

ALLERGIES: _____

PREOPERATIVE MEDICAL IMAGING ORDERS

☐ Chest X-Ray
☐ Other: _____

_____

CARDIOLOGY ORDERS: ☐ ECG

PRE-OP ANTIBIOTICS: _____

☐ See Doctor's Orders

OTHER ORDERS

☒ Anaesthesia Consult as Required
☐ Social Work Required ☐ Home Care Required

DAY OF SURGERY ORDERS

☐ Fasting Glucose
☐ Accuchek
☐ INR

OTHER PRE-OPERATIVE ORDERS:

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

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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.***