fraserhealth

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