



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 #				

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