PRE-OP ADMISSION ORDERS

Your signature will initiate the following orders. Checked items will be automatically implemented unless crossed out.

Identification	***Patient Name***	***Date of Service***
I. Diagnosis	***Diagnosis***	
II. Admission	ADMIT AS OUTPATIENT	
III. Clinical Assessment	❑ VITAL SIGNS + CLIN ASSESSMENT PER POLICY PER UNIT STANDARDS	
IV. Nutrition	❑ NPO	
V. Medications ****BEST PRACTICE ELEMENT****	• ANTI-INFECTIVES-PROPHYLAXIS FOR MILD OR NO BETA LACTAM ❑ CEFOXITIN 2 GRAM IVPB PRE-OP TO BE GIVEN WITHIN 0-60 MINUTES OF SURGICAL INCISION ❑ CEFOXITIN 1 GRAM IVPB PRE-OP TO BE WITHIN 0-60 MINUTES OF SURGICAL INCISION ❑ ANCEF (CEFAZOLIN) 1 GRAM IV PRE-OPTO BE GIVEN 0-60 MINUTES OF SURGICAL INCISION ❑ ANCEF (CEFAZOLIN) 2 GRAM IVPB 100 ML PRE-OP TO BE GIVEN WITHIN 0-60 MINUTES OF SURGICAL INCISION ❑ ANTI-INFECTIVES-PROPHYLAXIS FOR SEVERE BETA-LACTAM ALLERGY **BEST PRACTICE ELEMENT** • CLINDAMYCIN (CLEOCIN) _____ MILLIGRAM IVPB PRE-OP TO BE GIVEN WITHIN 0-60 MINUTES OF SURGICAL INCISION • GENTAMYCIN (GARAMYCIN) _____ MILLIGRAM IVPB PRE-OP TO BE GIVEN WITHIN 0-60 MINUTES OF SURGICAL INCISION ❑ VANCOMYCIN (VANCOCIN) 1 GRAM IVPB PRE-OP TO BE GIVEN WITHIN 0-120 MINUTES OF SURGICAL INCISION ❑ OTHER: _____	
VI. IV Fluids	❑ INSERT AND MAINTAIN IV/VASCULAR ACCESS ❑ LIDOCAINE 1% INTRADERMAL ONCE PRE-OP PRN ❑ LACTATED RINGERS 1000ML SOLUTION AT 50ML/HOUR ❑ NORMAL SALINE 1000ML SOLUTION AT 50ML/HOUR ❑ OTHER _____	
VII. Diagnostic Testing	❑ COMPLETE BLOOD COUNT WITHOUT DIFFERENTIAL ❑ COMPLETE BLOOD COUNT WITH DIFFERENTIAL ❑ COMPREHENSIVE METABOLIC PANEL ❑ BASIC METABOLIC PANEL ❑ PT / PTT / INR ❑ URINALYSIS WITH CULTURE AND SENSITIVITY ❑ HCG	❑ EKG ❑ CXR ❑ OTHER: _____ ❑ DIAGNOSTIC TESTING WAIVED BY SURGEON ❑ POINT OF CARE GLUCOSE METER ❑ POINT OF CARE URINE PREGNANCY TEST
VIII. Consults/Referrals	❑ CARDIAC CLEARANCE BY DR: _____ ❑ MEDICAL CLEARANCE BY DR: _____ ❑ MEDICAL EVALUATION BY DR: _____ ❑ H&P DONE BY DR: _____	
IX. Treatment/Intervention	❑ CONSENT FOR: _____ _____ _____ _____ ❑ SHAVE IN PRE-OP	OTHER _____
X. DVT Prophylaxis	❑ INTERMITTENT PNEUMATIC COMPRESSION, BILATERAL FOOT _____ KNEE _____ LENGTH IN OR ❑ ANTI EMBOLISM STOCKINGS BILATERAL THIGH _____ KNEE _____ LENGTH ROUTINE EFFECTIVE NOW	

RN Signature:	**DATE:**	**TIME:**	**MD Signature**	**DATE:**	**TIME:**

MEMORIALCARE®
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

WORK UP DONE BY
PCP (NAME) _____
QUEST DIAGNOSTICS _____
LAB CORP _____
OTHER _____

PATIENT STICKER

MEMORIALCARE SURGICAL CENTER SADDLEBACK MEMORIAL
HISTORY AND PHYSICAL

PATIENT NAME: DOB: AGE: DOS:

HISTORY
CHIEF COMPLAINT _____

_____

ALLERGIES: ☐ None

List: _____

_____

Reaction: _____

Latex Allergy: ☐ Yes ☐ No

MEDICATIONS/DOSE: _____

_____

_____

PAST MEDICAL HISTORY:

☐ Yes	☐ No	Bleeding Tendencies
☐ Yes	☐ No	Brain, Nerve, Muscle Disease
☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Heart Disease
☐ Yes	☐ No	Hypertension
☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Lung Disease
☐ Yes	☐ No	Infectious Diseases
☐ Yes	☐ No	Sleep Apnea
☐ Yes	☐ No	Other _____

SYSTEMS REVIEW: Please list problems with:

Cardio-Resp: No ☐ Yes ☐ _____
Endocrine: No ☐ Yes ☐ _____
GU/GI: No ☐ Yes ☐ _____
Neuro: No ☐ Yes ☐ _____
Vascular: No ☐ Yes ☐ _____

Past Surgical History: _____

_____

_____

Family History: ☐ Cancer ☐ Cardiovascular
☐ Diabetes ☐ Anesthesia Problems
☐ Non-Contributory

Social History: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Smoking _____ Alcohol _____

Drugs _____ Exercise _____

PATIENT LABEL

VITALS: B/P _____ P _____ R _____ T _____

PHYSICAL EXAMINATION: Ht: _____ Wt: _____

☐ Alert ☐ Oriented ☐ Other: _____

HEENT:	☐ Normal	☐ Abnormal	
HEART:	☐ Normal	☐ Abnormal	
LUNG:	☐ Normal	☐ Abnormal	
BREASTS:	☐ Normal	☐ Abnormal	☐ Deferred
ABDOMEN:	☐ Normal	☐ Abnormal	
PELVIC:	☐ Normal	☐ Abnormal	☐ Deferred
RECTAL:	☐ Normal	☐ Abnormal	☐ Deferred
EXTREMITIES:	☐ Normal	☐ Abnormal	

Explanation of Abnormal(s) listed above:

_____

_____

Examination of Operative Site:

_____

_____

Pre-Op Diagnosis: _____

_____

_____

Consent to Read: _____

_____

_____

_____

I have determined that this patient Is a suitable candidate for the planned procedure at this facility. I have reviewed the patient's vital signs and all diagnostic test results and will follow up as appropriate. The patient/guardian accepts the proposed procedural/surgical plan. Risks, benefits and alternatives to the proposed procedure(s), have been discussed with the patient and/or patient's authorized representative. I have provided an opportunity for questions and asnwers. The patient and/or patient's authorized representative has indicated understanding and consented to the procedure described above.

Physician Signature _____

Date _____ Time _____

H & P/Interval Note: Update Day of Surgery
Since the date of the patient's original evaluation, there have been no changes in the patient's pre-op diagnosis, chief complaint and procedure to be performed today. I have reviewed the patient's vital signs and all diagnostic test results and will follow up as appropriate. This patient is an appropriate candidate for outpatient surgery.

Physician Signature _____

Date _____ Time _____

MEMORIALCARE
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

Phone 949-614-8815

Surgery Scheduling Form

Please fax this form to
Surgery Scheduling: 866-993-6251

Surgery Date: _____ Surgery Time: _____ Surgery Length: _____

Surgeon: _____ Assistant: _____ Anesthesia: GEN MAC REG IV SEDATION LOCAL

Special Equipment / Implant Request: _____

_____

_____

Detailed List of Procedure(s): _____

_____

_____

Diagnosis: _____

CPT Procedure Codes: _____, _____, _____ ICD-10 Diagnosis Codes: _____, _____, _____

Patient Information:

Patient Name: _____

Patient DOB: ____/____/____ Patient SS # _____ Gender: Male Female

Patient Address: _____
Street Address City Zip Code

Patient Contact Number(s): H _____ W/Cell _____

Primary Insurance: **Cash ( )**

Insurance Company _____ Insurance Provider Phone # _____

Insured Name _____ Insured SS# _____

Insured Employer _____ Group/Policy# _____

Relationship to Patient _____ Insured Date of Birth _____

Pt's Ins Card ID # _____ (include all alpha prefixes)

Secondary Insurance:

Insurance Company _____ Insurance Provider Phone # _____

Insured Name _____ Insured SS# _____

Insured Employer _____ Group/Policy# _____

Relationship to Patient _____ Insured Date of Birth _____

Pt's Ins Card ID # _____ (include all alpha prefixes)

W/C: Claim # _____ DOI: _____ Adjustor: _____ Phone# _____

Claim Address: _____

DOCTOR'S OFFICE: IF SPOUSE OR PARENTS ARE THE INSURED INCLUDE INSURED MEMBERS NAME AND DOB

*****Please FAX a copy of *both sides* of the insurance card and Patient's (or parents) Driver's License*****

Scheduled With: _____ **Scheduled By:** _____

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