Northwestern Medicine

PATIENT LABEL

PRE-SURGICAL PHYSICIAN ORDERS

☐ **Northwestern Medicine McHenry Hospital**
Phone: 815.759.4370
Fax: 815.759.4371

☐ **Northwestern Medicine Huntley Hospital**
Phone: 815.759.4370
Fax: 815.759.4371

☐ **Admit Post-op Surgical** ☐ **Outpatient Surgical**

Patient Name ______________________ DOB __________ Age_______

If minor, parent/guardian name ______________________ ☐ Male ☐ Female ☐ X-gender

Home phone ______________ Cell ______________ Work______________

Street address ______________ City ______________ State ______ ZIP__________

Surgeon ______________________ Surgeon assistant ______________________

Primary care physician______________________ Admitting physician ______________________

H&P done by ______________________ Office notified: ☐ Yes ☐ No

H&P completed by PCP requires additional diagnosis ______________________

Admitting diagnosis ______________________ ICD-10 Code __________ CPT Code__________

Permit to read ____

____

Surgery date __________ Time __________ am/pm Requested length of case__________

Anesthesia type: ☐ General ☐ Spinal ☐ MAC ☐ Choice ☐ Local

Anesthesia consult for: ☐ Regional block ☐ Continuous regional block

PRE-SURGICAL TESTING **Surgical orders received:** **Initials:**

Pre-surgical orders according to Anesthesia Guidelines: G-2

ADDITIONAL TESTS (ICD-10 Code Required)

	Ordered	ICD-10	Completed		Ordered	ICD-10	Completed
CBC w/Diff		Z01.812		EKG		Z01.810	
Lytes		Z01.812		Chest X-ray		Z01.810	
BMP		Z01.812		Clot Tube			
CMP		Z01.812		Type & Screen			
HCG (qual)		Z01.812		Type & Crossmatch (# of units)			
Urinalysis		Z01.812					
Pro Time				HGB			
PTT				Other test:			
Thyroid Cascade				Other test:			

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Patient Name: **DOB:**

ADDITIONAL ORDERS

ALLERGIES ______________________________

Height ____________ **Weight** ____________ ☐ **Latex allergy**

History of: ☐ MRSA ☐ VRE ☐ C. diff

☐ **Sequential sleeves:** ☐ Knee high

☐ **AE stockings:** ☐ Knee high ☐ Thigh high

☐ **AE cuffs**

☐ Recommend prophylactic antibiotic ordered by pharmacy or select following option:

☐ MD ordered antibiotic

☐ No pre-op antibiotic

Prep & Clip ______________________________

OR special equipment needs:

Additional orders:

This question must be answered to proceed with scheduling:
Does the patient have a cardiac assistive device such as LVAD, ECMO, IABP, IMPELLA? ☐ Yes ☐ No

Time	**Date**	**Telephone Order Given By** (Please Print)	**Telephone Order Received By** (Please print/sign/verify read back)

Time ____________ **Date** ____________ **Physician's Signature** ______________________________

Physician's Name (Please Print) ______________________________ Physician ID # ____________

Insurance Information

Insurance name ______________________________ Phone number ( ) ____________

Subscriber name ______________________________
Last name First name Middle initial

ID # ______________________________ Group # ______________________________

Workers' Compensation

Employer name ______________________________

Date of injury ____________ Claim number ______________________________

Adjuster Contact Information:

Name ______________________________ Email ______________________________

Phone number ( ) ______________________________ Fax number ( ) ______________________________

Claim address ______________________________
Street or PO Box City State ZIP

Please provide a front and back copy of the insurance card.