Northwestern Medicine®

PRE-SURGICAL PHYSICIAN ORDERS

☐ **Northwestern Medicine McHenry Hospital**
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☐ **Northwestern Medicine Huntley Hospital**
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☐ **Admit Post-Op Surgical** ☐ **Outpatient Surgical**

Patient Name:_____ DOB: _____ Age: _____

If minor, parent/guardian name_____ ☐ Male ☐ Female

Home phone: _____ Cell: _____ Work: _____

Street address: _____ City: _____ State: _____ ZIP:_____

Surgeon:_____ Surgeon Asst:_____

Primary care physician:_____ Admitting physician:_____

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

H&P completed by PCP requires additional diagnosis: _____

Admitting diagnosis: _____ ICD10 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

Lab testing site: ☐ **CHS** ☐ **Other:**____ **EKG Testing Site:** ☐ **CHS** ☐ **Other:**____ **Pre-surg test date:** _____

ADDITIONAL TESTS (ICD-10 Code Required) *If Medicare recipient, complete ABN for Medicare limited frequency/medical necessity - see back*

	Ordered	ICD-10	Completed
*CBC		Z01.812	
Lytes		Z01.812	
BMP		Z01.812	
CMP		Z01.812	
HCG (qual)		Z01.812	
*Urinalysis		Z01.812	
*Pro Time			
*PTT			
*Thyroid Cascade			

	Ordered	ICD-10	Completed
EKG		Z01.810	
Chest X-ray		Z01.810	
[1]Clot Tube			
Type & Screen			
Type & Crossmatch (# of units)			
Autologous (# of units)			
HGB			
Other test:			
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 Hi

☐ **AE Stockings:** ☐ Knee Hi ☐ Thigh Hi

☐ **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:

_____	_____	_____	_____	_____
Physician's Name (Please Print)	**Physician Signature**	**ID#**	**Date**	**Time**