PRE-SURGICAL PHYSICIAN ORDERS TOTAL JOINT SURGERIES—FOR TOTAL JOINT PATIENTS ONLY

Northwestern Medicine Huntley Hospital
Phone: 815.759.4902
Fax: 847.802.7403

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

Anesthesia: □ General □ Spinal □ Choice
Anesthesia type: □ Femoral nerve block
□ Sciatic nerve block □ Adductor canal block
□ Popliteal nerve block □ IPACK block
Anesthesia consult for: □ Single shot □ Continuous catheter

PRE-SURGICAL TESTING              Surgical orders received:                           Initials:
Pre-surgical orders according to anesthesia guidelines

ADDITIONAL TESTS (ICD-10 Code Required)  \(^2\)Clot to hold will be auto substituted for Total Knee Arthroplasty procedures.

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Ordered</th>
<th>ICD-10</th>
<th>Completed</th>
<th>Ordered</th>
<th>ICD-10</th>
<th>Completed</th>
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</thead>
<tbody>
<tr>
<td>CBC w/Diff</td>
<td>Z01.812</td>
<td>EKG</td>
<td></td>
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<tr>
<td>Lytes</td>
<td>Z01.812</td>
<td>Chest X-ray</td>
<td></td>
<td>Z01.810</td>
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<tr>
<td>BMP</td>
<td>Z01.812</td>
<td>Clot to Hold (TKA)</td>
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<tr>
<td>CMP</td>
<td>Z01.812</td>
<td>Type &amp; Screen (THA)</td>
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<tr>
<td>HCG (qual)</td>
<td>Z01.812</td>
<td>~On Admit</td>
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<tr>
<td>Urinalysis</td>
<td>Z01.812</td>
<td>MRS Swab</td>
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<tr>
<td>Pro Time</td>
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<td>Spirometry</td>
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<tr>
<td>PTT</td>
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<td>Dobutamine Echo</td>
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<tr>
<td>Thyroid Cascade</td>
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<td>Lexiscan stress test</td>
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<tr>
<td>Hemoglobin A1C</td>
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<tr>
<td>Draw 1 extra tiger top tube (protect from light)</td>
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</tbody>
</table>
### Allergies

- **Height:** __________
- **Weight:** __________
- **Latex allergy:** ☐

**History of:**
- ☐ MRSA
- ☐ VRE
- ☐ C. diff
- ☐ Sequential stockings: ☐ Knee high  ☐ Thigh high
- ☐ AE stockings: ☐ Knee high  ☐ Thigh high
- ☐ AE boots

**Implement TKA Peri-operative Pain Protocol**
**Implement Adult Prophylactic Antibiotic Hospital Protocol**
for ________________________________ (procedure)

**IV:** LR, 1L, TKO
**Prep & Clip** __________________________________________

**Requested length of case:**

**Instruct patient to:**
- **3 days prior to surgery:** Shower or bathe with 4% chlorhexidine gluconate soap.
- **Day of surgery:** Apply 2% chlorhexidine gluconate to surgical site prior to procedure.

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

**Physician’s Name** (Please Print) __________________________________________

**Time** __________  **Date** ___________  **Physician’s Signature** __________________________________________

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**Insurance Information**

**Insurance name** __________________________________________  **Phone number ( )** __________________________________________

**Subscriber name** __________________________________________

- **Last name**
- **First name**
- **Middle initial**

**ID #** __________________________________________  **Group #** __________________________________________

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**Workers’ Compensation**

**Employer name** __________________________________________

**Date of injury** __________________________  **Claim number** __________________________________________

**Adjuster Contact Information:**

- **Name**
- **Email**
- **Phone number ( )**
- **Fax number ( )**

**Claim address** __________________________________________

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