



HSHS
St. John's
Hospital

**SURGERY SCHEDULING/
PHYSICIAN ORDER**

Main & OSC
217-757-6060 Phone
Fax all preadmission information
to 217-757-6018

Cardiac Surgery
1-866-466-8707 (press 1) Phone
217-544-6464, ext. 50501 Local Phone
Fax all preadmission information
to 217-757-6008

Surgery Suites
217-544-6464, ext. 50300 Phone
Fax all preadmission information
to 217-757-6494

Tracking # _____ Issued by _____

Procedure date: ____/____/____ Patient status: Outpatient AM admission (IP)

Surgeon: _____ Length of procedure: ____ hrs

Time: _____ TF: _____

Procedure(s) / consent for: _____

- Bilateral _____
- Left _____
- Right _____
- Levels _____ CPT Code: _____

Positioning: _____ OR table: _____

Supplies/System/Equipment requests: _____

Rep. notified: Yes No N/A

Anesthesia type: General Local Monitored anesthesia care Bier Block Spinal/Epidural Anesthesia choice

Post-op pain block requested by surgeon Post-op level of care: General IMC ICU

Patient name: _____ Male Female
(First) (MI) (Last)

DOB: ____/____/____ Social Security # _____ - _____ - _____ Email: _____

Home address: _____

Phone# : _____

Insurance carrier: _____ Precert #: _____

If Medicare/Medicaid, length of stay: ____ Ht: ____ Wt: ____ BMI: ____

Allergies/Adverse reactions: _____

Films to be brought by: Physician Nurse Resident Patient

Physician for H&P: _____ Phone: _____

Primary Physician: _____ Phone: _____

Hospitalist Service: HSHS SIU Springfield Clinic Reason: _____

Cardiologist: _____ Phone: _____

Pre-op diagnosis _____ ICD-10 code: _____

ADMIT ORDERS:

Pre-Op Antibiotics _____ On call to OR None

NPO p midnight CHG wipes

Order set to be used: _____ Pre-Op order set to be used: _____

Hold ACE inhibitors 24 hrs prior to surgery.

Beta Blockers: Instruct patient to take beta blockers as prescribed day of surgery.

FAX ALL PRE-ADM. ORDERS, H&P, CONSENTS AND TESTING RESULTS WITH THIS FORM.

Check all that apply:

- Latex allergy
- MRO
- VRE
- Needle loc ____ (time)
- MRI ____ (time)
- CT ____ (time)
- Nuc Med ____ (time)
- SSEP
- Ultrasound
- Cell saver
- Translator

PRE-OP TESTING

- Anesthesia Protocol
- EKG PT/INR
- Chest X-ray PTT
- CBC w/diff U/A
- BMP Urine C&S
- CMP UHCG
- MG
- Nasal swab for MRSA within 14 days
- Type & screen (if antibodies present, proceed to a Type & Cross)
- Type & cross ____ units within 14 days
- Other: _____

Testing location: _____

Office Task List

- Scheduler Insurance
- Vascular Lab, Nuc Med, EEG, Needle loc

PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____



