



Authorization is given for dispensing by nonproprietary name or therapeutic equivalent as approved by the medical staff unless noted.

When Choice Available- Activate by Checking

FAX: (304) 526-1849

This order with confirmation number will be faxed back to your office. Cases should be posted in our system by next business day. If you do not receive this return fax or have questions call (304) 526-1048.

Patient Demographics (Please provide copy of patient demographic and insurance information, if possible.)

Last Name: _____ First Name: _____ Sex: _____
DOB: ____/____/____ SS#: _____ Home Phone: _____
Work / Other Phone: _____ Patient special needs (hearing impaired, blind, etc): _____
Insurance Co. _____ Policy # _____ Pre-cert # _____

Surgery Date: ____/____/____ Start Time: _____ am/pm

Surgeon: _____ Phone #: _____ Fax #: _____

Scheduled by: _____ Patient Arrival Time: _____

Surgical Procedure: (Do not abbreviate – Include CPT Code): _____

Diagnosis: _____

Latex Allergy: Yes No Pacemaker / AICD: Yes, Company _____ No

Anesthesia Type: General IV Sedation MAC Block Local _____

Anesthesia Group: RCA CAP

SPECIAL EQUIPMENT / INSTRUMENTS	PAT ORDERS / DAY OF SURGERY ORDERS
<input type="checkbox"/> C-Arm <input type="checkbox"/> Stealth <input type="checkbox"/> Cell Saver <input type="checkbox"/> Laser Type _____ <input type="checkbox"/> Laminar Air <input type="checkbox"/> Microscope <input type="checkbox"/> Ultrasound <input type="checkbox"/> Instatrak <input type="checkbox"/> Ultrasound & Tech <input type="checkbox"/> Special instruments/wound vac not kept at SMMC: company rep notified to have instruments with list at SMMC at least 72 hours in advance. <input type="checkbox"/> Other _____	<input type="checkbox"/> Use Anesthesia PAT Protocol <input type="checkbox"/> SCD's <input type="checkbox"/> Thigh Hi TEDS <input type="checkbox"/> Other _____ <input type="checkbox"/> Testing done at outside facility. Please indicate facility and tests that were done _____

Admission Status: Outpatient Inpatient Admission

Physician Signature: _____	Date/Time _____ <input type="checkbox"/> am <input type="checkbox"/> pm	Estimated Length Of Stay In Midnights: <input type="checkbox"/> ≥ 2 MNs <input type="checkbox"/> < 2 MNs
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OS547 Surgery Order

Adopted Date: 11//13

Revised Date: 8/14

Reviewed Date: