ST. MARY'S MEDICAL CENTER

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

- ☐ C-Arm
- ☐ Cell Saver
- ☐ Laminar Air
- ☐ Ultrasound
- ☐ Ultrasound & Tech
- ☑ Stealth
- ☑ Laser Type _____
- ☐ Microscope
- ☐ Instatrak
- ☐ Special instruments/wound vac not kept at SMMC: company rep notified to have instruments with list at SMMC at least 72 hours in advance.
- ☐ Other _____

PAT ORDERS / DAY OF SURGERY ORDERS

- ☐ Use Anesthesia PAT Protocol
- ☐ SCD's
- ☐ Thigh Hi TEDS
- ☐ Other _____
- ☐ Testing done at outside facility. Please indicate facility and tests that were done _____

Admission Status: ☐ **Outpatient** ☐ **Inpatient Admission**

Physician Signature:	Date/Time ☐ am ☐ pm	Estimated Length Of Stay In Midnights: ☐ ≥ 2 MNs ☐ < 2 MNs

Submit Form