McLaren
THUMB REGION

1100 Van Dyke Avenue
Bad Axe, Michigan 48413

SURGICAL SCHEDULING FORM

- Dear Patient: Please bring this sheet with you on the date and time listed below to see the anesthesiologist. You will receive further instructions at that time. Thank you.
- Appointment: Please report directly to the AMBULATORY SURGERY DEPARTMENT on the second floor of McLaren Thumb Region for your interview with anesthesia and nursing on _____, 20_____ at _____am/pm.
- Phone Interview: **Indicate a date and time for phone interview, 8AM-11AM or 1-4:00PM Monday, Wednesday or Thursday:**_____
- **BLOOD DONATION APPOINTMENTS:____-____-____ at _____am/pm & _____-_____-____ at _____am/pm**
- **PHYSICAL THERAPY EVALUATION: ____-____-____ at _____am/pm in the Physical Therapy Dept.**
- **MEDICAL ASSESSMENT WITH DR. _____ on____-____-____ at_____ am/pm**

Patient Name_____ Date of Surgery:_____

Diagnosis_____

Surgery:_____

_____

Special Equipment / Prothesis Needed | Name of Rep notified | Rep's Phone #

Classification: I/O AMB IN/AM admit

Proposed anesthesia: General Local Sedation Spinal Regional

Patient Address:_____ Patient Phone #:_____

____-____-____ _____ _____ _____ _____

Date of Birth | Age | HT | WT | Co-Morbidities

Legal Guardian:_____ Legal Guardian Phone:_____

All pre-surgical testing must be diagnosis specific. List the diagnosis and put the letter in front of the test to be done.

Diagnosis: A) _____ B) _____

LAB TESTS:

____H&H ___CBC___CBC with differential ____PT ____INR ____PTT ____Bleeding Time ____Type & Screen ____Type & Crossmatch for ____units

____Electrolytes ____Basic metabolic ____Comprehensive metabolic ____Complete UA · ____Urine Culture ____ Urine Cytology

____U Dip w/Reflex to Complete UA ____Serum Pregnancy Test today ____Other: _____ ____Other: _____

LAB TESTS THE DAY OF SURGERY:

____H&H ____Blood Draw and Band ____Urine Pregnancy Test ____FBS ____PT ____Electrolytes ____Other: _____

Diagnosis: A) _____ B) _____

DIAGNOSTIC IMAGING (X-ray): Chest x-ray _____ IVP_____ Renal Ultrasound _____ Other: _____

Diagnosis: A) _____B) _____

CARDIOPULMONARY: ____ Arterial Blood Gasses ____Pulmonary Function test ____ECG: ____do at Dr.'s office____do at MTR, Dr. _____to read

Surgeons Orders on admission:

____Daily follow-up by medical physician
____Surgical Hair Removal
____ IV_____
____Anticoagulant Orders_____
____Flowtrons ____Ted Hose: Thigh
____Contraindications to VTE Prophalaxis _____
____Intra Operative Cultures—No pre-op Antibiotics

____Other:

_____
Surgeon Signature

Would the patient benefit from further work-up/diagnostics? _____Y _____N Comments:

Medical Physician Risk Assessment:

_____No major risks present, stable for surgery without further work-up
_____Intermediate risk for cardiovascular event
_____Major risk for cardiovascular event
_____Cardiac Consult with:_____Date:_____

_____
Medical Assessment Physician Signature