MERCY HEALTH
SAINT MARY'S

SURGERY REQUEST FORM- Fax to **312-579-3450**

REQUESTED SURGERY DATE: REQUESTED TIME:
FIRST NAME: LAST: MI:
DATE OF BIRTH: GENDER: M ☐ F ☐

SURGEON(S): Estimated Length of Procedure:
PCP Name: PCP Phone #:

PROCEDURE TO BE DONE:***(No abbreviations)*** **Side? Right ☐ Left ☐** **CPT code:**

DIAGNOSIS / SIGNS & SYMPTOMS:

ANESTHESIA TYPE: ☐ Local ☐ MAC ☐ General ☐ Spinal ☐ Epidural ☐ Nerve Block **(location):**
☐ Anesthesia Other Type:

ADMIT STATUS: ☐ ***Surgery to the floor (Inpatient)***
☐ ***Hospital Outpatient Surgery (Ambulatory Surgery) Planned discharge from hospital unit***
☐ ***Hospital Outpatient Surgery (Ambulatory Surgery) Planned discharge from surgery unit***

EQUIPMENT REQUESTS: (*Use this section for NON Inventory Items*): ☐ C-Arm ☐ Mini C-Arm ☐ O-Arm ☐ Sonapet ☐ First Assist
☐ Cell Saver ☐ Intraoperative Neuro Monitoring ☐ Fluid management system ☐ Hybrid ☐ Laser (type):
☐ Other:

KEY MEDICAL INFORMATION: Hx Malignant Hyperthermia ☐ Yes ☐ No Hx of Diabetes: ☐ Yes ☐ No Height _____in. Weight:____lbs
Name of Cardiologist: _____Last Seen: _____ Pacemaker/AICD: ☐ Yes ☐ No Last Checked:_____
Heart Procedures/Tests_____ When:_____ Where:_____
Allergies/Reactions:_____
Special Needs: ☐ Interpreter Language:_____ English Speaking Name/Phone:_____
Patient has Legal Guardian ☐ Yes ☐ No Name of Legal Guardian:_____ Contact # of Legal Guardian:_____

Surgeon Ordered: Completed Prior to Surgery	Day of Surgery Orders
☐ CBC ☐ BMP ☐ CMP ☐ PT/INR ☐ PTT ☐ A1C ☐ PFT ☐ CXR ☐ EKG ☐ UA C&S (if greater than 5 WBCs) ☐ T&S (must complete @ Mercy Health facility within 10 days of scheduled procedure) ☐ Other: Labs Drawn @:	☐ Lab Work Day of Surgery: ☐ Other: ☐ KUB ☐ Pneumatic Compression Devices ☐ TED Hose Initiate forced air warming unless declined ☐ Declined Initiate Preop patient care orders and preference card unless declined ☐ Declined Start IV with 1000 mL Lactated Ringers at 50 mL per hour unless declined ☐ Declined If renal patient, 500 mL Normal Saline at 50 mL per hour unless declined ☐ Declined
Patient Referred for Pre-op Evaluation	**Pre-Operative Medications** ☐ Pre-op Medication Orders To Follow (separate pg.)
☐ None ☐ PCP ☐ Cardiologist ☐ Pulmonologist ☐ Other	☐ Heparin 5000 units subcutaneously 1 hour pre-op (not in abdomen for abdominal procedure) ☐ Betadine nasal swabs- 2 swabs per nostril 1 hour prior to surgery (Ortho, Neuro, Vascular) ☐ Cefazolin (Ancef) 2gm (3gm if weight equal to or above **120 kg/ 264 lbs**) IVP pre-op ☐ *ALLERGY TO PENICILLIN*: Pharmacy to dose per protocol ☐ Other (s):

INSURANCE INFORMATION	**PATIENT CONTACT INFORMATION**
Last 4 digits of SSN: Insurance Name: Insurance Contract #: Authorization #	Home Address: City: State: Zip: Patient at extended care facility? ☐ Yes Facility Name: Patient Best Contact Number: 2nd Phone Number: Emergency Contact Name/Number: Emergency Contact Relationship to Patient:

Physician Signature: Date: Time:

Scheduler Contact Name/Phone Number: Date Faxed: