

# SURGERY SCHEDULING

Date: \_\_\_\_\_ Docto: \_\_\_\_\_

Assistance Requested:      Yes      No                      With: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Acct. #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Procedure: \_\_\_\_\_

Special Equipment: \_\_\_\_\_

Type of Anesthesia:    Local    General    Bier Block    Stand-by    Spinal    Other \_\_\_\_\_

Surgery Time: \_\_\_\_\_ Length of Stay: \_\_\_\_\_

Estimated Time Out of Work: \_\_\_\_\_ Date of Surgery Requested: \_\_\_\_\_

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Date Posted: \_\_\_\_\_ By: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Admission Clerk: \_\_\_\_\_ Surgery Clerk: \_\_\_\_\_

Date Patient Notified: \_\_\_\_\_ Phone: \_\_\_\_\_ Letter: \_\_\_\_\_ In Person: \_\_\_\_\_

NPO \_\_\_\_\_ DND \_\_\_\_\_ PAT \_\_\_\_\_ CL \_\_\_\_\_ FMP \_\_\_\_\_ Fax Orders \_\_\_\_\_

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Comments:

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Pre-op medical clearance needed?    Yes    No    Date received: \_\_\_\_\_

With: \_\_\_\_\_

(Doctor's Name)

Autologous Blood Requested:    Yes    No    No. of Units \_\_\_\_\_ Form Sent:    Yes    No