

**Presurgical Physician Orders**

**FAX to 1-888-555-12312- Pre-Admission Testing when reservation made**

**If Inpatient or Ext. Recovery bed needed, also fax to 1-888-555-1313- bed control**

**Call 1-888-555-1414 for reservations**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of Arrival: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Read: (please spell out complete surgery with no abbreviations, specify left and right) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code(s) of procedure: \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pre-auth Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Status: (check one): \_\_\_Inpatient \_\_\_Day Surgery \_\_\_Extended Recovery

Note: Observation cannot be ordered pre-op; for use only after routine recovery.

Extended Recovery should be chosen for overnight stays that are part of routine recovery.

Refer to www.shermandocs.com for list of surgeries that must be done as Inpatient and require pre-op inpatient order.

Anesthesia guidelines for medical necessity will be followed for all procedures with anesthetic.

Other Pre-admission Orders/Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_Please initiate pre-procedure orders upon patient arrival.

Other Pre-procedure Orders/Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff completing form:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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