BOOKING REQUEST / PRE-ADMIT ORDERS

PHONE NUMBER: 561-784-3128 eFAX NUMBER: 561-273-0120

Patient Name: | **Surgery Date:** | **Time:**

Procedure:

ICD10:

CPT:

Surgeon:

Sex: M F DOB: ____________SS#: ______________

Address: ________________________________

City: __________________ ST ______ Zip _________

Interpreter needed: ___________________________

Insurance 1: _____________________________

Policy 1 #: ______________________________

Insurance 2: _____________________________

Policy 2 #: ______________________________

PCP Name: ______________________________

SPECIAL REQUEST:

☐ Laser ☐ Gamma Probe ☐ Cell Saver ☐APC

☐ C-Arm ☐ Mini C-Arm ☐ Stealth

☐ Myosure/Aquilex ☐ Novasure

☐ Neuro Monitoring

☐ Implants: __________________________

☐ Bone/Tissue Graft: ____________________

☐ Specialty Instruments: _________________

Vendor Name: ___________________________

Vendor Number: _________________________

Email Address: ______________________________

Pt. Phone #1 (mobile): ________________________

Pt. Phone #2: ______________________________

☐ Inpatient ☐Outpatient

Expected Level of Anesthesia:

☐ General ☐ MAC ☐ Regional ☐ Local ☐ Block

Pre-Op Date/Time: __________________________

PRE-ADMIT ORDERS:
Pre-Op eFax #: 561-273-0120
Telephone #: 561-784-3119

☒ Enhanced Surgical Recovery if Appropriate

☒ MRSA/MSSA Screening and Decolonization Protocol
(Required for patients with planned implants)

☒ Initiate Pre-Operative Anesthesia Guidelines

☐ COVID test

☐ Request Hospitalist to Consult/Follow Up Post-Op Admissions

Provider Specific Pre-Admit Orders:
(Anesthesia Guidelines will Order Appropriate Screening Test)

☐ CBC w/auto ☐ CBC w/no diff ☐ UA C&S

☐ Comp Metabolic ☐ Basic Metabolic ☐ Chest X-Ray

☐ PTT ☐ PT/INR

☐ Type & Screen ☐ Type & Cross, # of units _______

☐ EKG: Indication ___________________________

☐ Other: ___________________________________

OPTIMIZATION NEEDED:

☐ Medical ☐ Cardiac ☐ Other as Needed: __________

Physician/PA
Signature: ______________________________________ **Date:** ___________ **Time:** ___________

Palms West Hospital - Loxahatchee, FL 33470
BOOKING REQUEST-PRE ADMIT ORDERS

Patient Identification/Label