



1441 N. Beckley Avenue
 Dallas, Texas 75203
 Scheduling - 214-947-1650
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GENERAL - GYN - VASCULAR - PODIATRY

Patient Name: _____ DOB: _____ Male Female ERAS
 MHD# or SS#: _____ Phone: _____ Phone: _____

Insurance: _____ Policy Holder: _____
 Authorization Required Y / N : _____ Policy Number: _____
 (If YES, please provide authorization number)

Ordering Physician: _____ Date of Procedure: _____ Time of Procedure: _____
 Procedure Description: _____
 Right Left Bilateral Type of Anesthesia:
 Procedure Length: _____ Inpatient Outpatient General
 CPT Codes: _____ Local
 Diagnosis / ICD-10 Codes: _____ Other: _____

<input type="radio"/> Frozen Section	<input type="radio"/> Spy Phi	<input type="radio"/> Savi Scout	<input type="radio"/> Lateral Positioners
<input type="radio"/> Mesh _____	<input type="radio"/> Cell Saver	<input type="radio"/> Neoprobe	<input type="radio"/> Prone
<input type="radio"/> Endovascular Table	<input type="radio"/> C-arm	<input type="radio"/> TrueNode	<input type="radio"/> Supine
<input type="radio"/> Graft Size _____	<input type="radio"/> Mini C-arm	<input type="radio"/> Faxitron	<input type="radio"/> Aquilex Fluid Mgmt. System
<input type="radio"/> Wound Vac	<input type="radio"/> Block (anes)	<input type="radio"/> Ultrasound	<input type="radio"/> Truclear Fluid Mgmt. System
<input type="radio"/> Misonix	<input type="radio"/> Lithotomy Candy Cane	<input type="radio"/> NIM	<input type="radio"/> Other _____
<input type="radio"/> BIS Monitor	<input type="radio"/> Lithotomy Yellow Fins	<input type="radio"/> Novasure	

Additional Instructions : _____ Vendor: _____
 Antibiotics: _____ Allergies: _____ Vendor Phone #: _____

Pre-op Labs and Outpatient Studies (EKG, Chest X-ray)	Non-standard Labs or Studies not covered by Anesthesia Protocol
Pre-Assessment Testing -Routine pre-op lab testing NOT RECOMMENDED without Clinical indications Timing of Laboratory Testing -Normal tests are reliable for 4 months (unless patient's clinical status changes) <input type="checkbox"/> Anesthesia Protocol Testing (RECOMMENDED DEFAULT ORDERSET) Pre-op labs and testing per Anesthesia protocol (Includes Clinically indicated Labs, and Studies (EKG & CXR))	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>

Circle Below To Indicate Documents You Will Be Providing Prior To The Day Of Surgery To Expedite The Pre-Assessment Process

H&P	Consent	Labs	EKG	Medical/Cardiac Clearance
		(Expedites pre-assessment process please send Labs <u><4mo</u> old if available)	(Expedites pre-assessment process please send EKGs <u><6mo</u> old if available)	(If clearance was not obtained please send last PCP and/or Cardiologist note if available)

Physician Signature: _____ Physician Printed Name: _____ Date: _____ Time: _____

AFFIX PATIENT LABEL HERE