Methodist DALLAS

ORTHO - NEURO

1441 N. Beckley Avenue
Dallas, Texas 75203
Scheduling - 214-947-1650
Fax - 214-947-3863

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

Procedure Length: _____ ○ Inpatient ○ Outpatient

CPT Codes: _____

Diagnosis / ICD-10 Codes: _____

Type of Anesthesia:

○ General
○ Local
○ Other:_____

○ Hana Table	○ C-arm / Fluoro	○ Stealth	○ Microscope
○ Jackson Flat Top	○ O-arm / Navigation	○ Mayfield	○ Prone
○ Jackson Axis	○ Mini C-arm	○ Horseshoe	○ Supine
○ Pro Axis	○ Ultrasound	○ Diving Board	○ Sitting
○ Jackson Bed with Levo	○ Cell Saver	○ Beach Chair	○ Lateral Positioners
○ Regular Bed	○ Neuro Monitoring	○ Wound Vac	○ Allograft: _____
○ Regular Bed with Wilson	○ Chest Rolls		

Additional Instructions : _____

Antibiotics: _____ Allergies: _____

Vendor: _____

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)	○ ○
	○ ○
☐ **Anesthesia Protocol Testing (RECOMMENDED DEFAULT ORDERSET)**	○ ○
Pre-op labs and testing per Anesthesia protocol	**Additional Notes**
(Includes Clinically indicated Labs, and Studies (EKG & CXR))	

Circle Below To Indicate Documents <u>You Will Be Providing</u> 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