CHESAPEAKE REGIONAL HEALTHCARE

1PO

SURGICAL ORDER POSTING FORM

ALL INFORMATION MUST BE COMPLETED OR CASE WILL NOT BOOKED

Patient Status: Inpatient – Patient to be admitted post-operatively
Outpatient in a bed – Patient may require an overnight stay
Outpatient Home – Patient will not require an overnight stay

☐ **OP-Bed** ☐ **OP-Home** ☐ **INPT (ROOM#_____)**

OR Main Desk: 312-6151
Posting Direct Line: 312-6136
Posting Fax Line: 312-4254

☐ **PSAT Onsite visit** ☐ **PSAT Telephone Interview** ***(based off of Triage Questionnaire)***

Date of Surgery:_____ **Time:**_____ **Case #:** _____

Surgeon:_____ **Time Required:**_____ **CPT:**_____

Procedure:_____

Diagnosis:_____ **Diagnosis Code**: _____

Equipment/Special Requests: ☐C-Arm ☐Mini C-Arm ☐Portable X-Ray ☐Cell-Saver/Brat ☐Laser ☐NIMS
☐Penter Microscope ☐HANA ☐BMAC ☐MYOSURE ☐NOVASURE ☐Stealth ☐Coblator

Tables: ☐CHIK ☐Fracture ☐Jackson_____ ☐Macquet ☐McCullough Retractor ☐Wilson Frame

☐ **Surgical Assistant**: _____ **Sales Rep** Needed? ☐Yes ☐No **Rep Notified?** ☐Yes ☐No

Rep Name: _____

Patient Name:_____ **Former Name:**_____

☐ ***Fax Copy of Patient's Demographic Sheet***

DOB:_____ **SS#:**_____ **Sex:** ☐Female ☐Male ☐Other

Phone Numbers: Home:_____ Cell:_____ Work:_____

Anesthesia: ☐General ☐Spinal ☐Epidural ☐Local ☐MAC/IV Sedation ☐Regional Block Type:_____ Supraclavicular

Insurance Information:	☐ **Fax Copy of Insurance Card** ***(Front and Back)***
If Copy of Card is Not Faxed, Then Complete The Insurance Information Below.	
PRIMARY INSURANCE	**SECONDARY INSURANCE**
Company Name:_____	Company Name:_____
Insurance Policy #:_____	Insurance Policy #:_____
Pre-cert Number:_____	

Please Check Yes or No For The Following:			
Latex Allergy	☐Yes ☐No	Iodine Allergy	☐Yes ☐No
Contact Isolation	☐Yes ☐No	Malignant Hyperthermia	☐Yes ☐No
MRSA	☐Yes ☐No	Weight Greater Than 300 LBs	☐Yes ☐No

Is patient on Aspirin/Anticoagulants/Antiplatelet? (circle one). If yes, can surgery be performed with patient on therapy? ☐Yes ☐No

Scheduler Name:_____ **Fax#:**_____

Physician's Signature:_____ **Date/Time:**_____

Patient Label