North Memorial Health Care

SURGERY DATE:_____
SURGERY TIME:_____
ARRIVAL TIME:_____

Surgery Scheduling Form

Patient's Name_____D.O.B_____Gender M F

Medical Record #_____SS#_____

Parent/Guardian (if patient is a minor)_____

Phone (Home)_____(Work)_____(Cell)_____

Films Y N Location of Films_____

Latex Allergy Y N Interpreter Y N Language Needed _____

Special Needs DIABETIC WHEELCHAIR OTHER_____

Surgeon_____Assistant_____

H&P Physician_____

CRITICAL COMPONETS (to be completed by surgeon performing procedure)

Pre-Op Diagnosis:_____

Procedure Location (*circle*) Right Left Bilateral

Procedure to be Performed: _____

Case Length:_____Anesthesia (*circle*) General MAC Local Regional

Patient Type (*circle*) IP SDS Observation(2359) ADMIT: FOLLOWING (AFS) PRIOR (APS)

Positioning:

Infection/Isolation (*circle*) Y N If yes, what type? _____

ORTHOPEDIC SPECIALS:

Total Prosthesis (list) _____Cemented? Y N

Hardware Needed (list)_____

Equipment Needed: (circle) **C-Arm/ Mini Large** **Microscope** **Ultra Drive**

(list other)_____

SCHEDULED BY: PHYSICIANS OFFICE _____

SCHEDULING OFFICE_____