Surgery Scheduling #: (909) 920-4975
Fax #: (909) 920-4727
POC: (909) 920-4924

San Antonio Regional Hospital
PRESURGICAL SCHEDULING REQUEST/ORDERS

☐ ***Check this box if this is an update to a previous request sent***

Patient Name:	**Any Previous Name:**	**Date Submitted:**
Requested Procedure Date:	Requested Procedure Start Time:	
Requested Length of Procedure:	Surgeon:	
Assistant Surgeon:	Co-surgeon:	

Special Equipment/Request:

Type of Anesthesia: ☐ General ☐ Regional ☐ MAC ☐ Local ☐ Spinal Anesthesia

Pre-Op Diagnosis (written out):

PATIENT DEMOGRAPHIC INFORMATION: Name of Person Completing Document:

Sex: ☐ Male ☐ Female SSN: DOB: SARH MR#:

Language Spoken: ☐ English ☐ Spanish ☐ Other:

Address: Home #: Work #:
Cell #: Other #:

Insurance Name: Member Name:

Group: Policy/ID #: Insurance Authorization Number/**Required**:

CPT 4 Code: ICD-10 Code: Primary Care Physician:

Orders:

☐ PRE-OP TESTING PER ANESTHESIA PROTOCOL (OR COMPLETE THE SECTION BELOW)

☐ Pre-Op orders to be completed regardless if done within Anesthesia Timeline

☐ EKG:_____ ☐ Basic Metabolic Panel: _____

☐ Chest X-ray: _____ ☐ UA: _____ ☐ C&S: _____

☐ CBC: _____ ☐ Protime/INR: _____ ☐ HCG Qualitative: _____

☐ Type, Screen and Crossmatch: _____units ☐ A1C: _____ ☐ Other: _____

Place in Ambulatory Status: (Protocol for all patients)

Expected Stay: ☐ Outpatient Surgery ☐ Inpatient Surgery Expected LOS _____ nights

Patient Care:

☐ Graduated Compression Stockings ☐ Knee High ☐ Thigh ☐ Intermittent Compression

Medication:

☐ If patient on Beta Blocker and has not taken it within 24 hours of planned incision time, order one dose now.

☐ Antibiotics: ☐ Per SCIP Protocol _____ (name and dose)

☐ Other _____ (name and dose)

☐ Other Medication Orders _____ (name and dose)

_____ (name and dose)

Consent to Read (No abbreviations allowed):

_____

_____

_____

_____ _____ A.M. / P.M. _____

Date (Required) Time (Required) Physician Signature (Required)

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