



3-Mole 5/16 4 1/4 c-to-c

SN

SN

<input type="checkbox"/> EKG	_____	Diagnosis	_____
<input type="checkbox"/> Chest x-ray PA and lateral	_____		_____
LABORATORY STUDIES		Diagnosis	
<input type="checkbox"/> Hemoglobin and hematocrit	_____		_____
<input type="checkbox"/> Complete blood count	_____		_____
<input type="checkbox"/> Electrolytes	_____		_____
<input type="checkbox"/> Blood glucose	_____		_____
<input type="checkbox"/> BUN/Creatinine	_____		_____
<input type="checkbox"/> Basic metabolic panel	_____		_____
<input type="checkbox"/> AST	_____		_____
<input type="checkbox"/> ALT	_____		_____
<input type="checkbox"/> Albumin	_____		_____
<input type="checkbox"/> Complete metabolic panel	_____		_____
<input type="checkbox"/> Prottime/PTT	_____		_____
BLOOD BANK			
<input type="checkbox"/> Type and screen	_____		_____
<input type="checkbox"/> Type and crossmatch _____ units packed RBC's for surgery	_____		_____
<input type="checkbox"/> Other _____	_____		_____
PLEASE OBTAIN RESULTS OF PAST STUDIES:		Approximate date, facility, physician, phone number	
<input type="checkbox"/> Old EKG	_____		_____
<input type="checkbox"/> Stress test	_____		_____
<input type="checkbox"/> Cardiac cath	_____		_____
<input type="checkbox"/> Echocardiogram	_____		_____
<input type="checkbox"/> Pulmonary function tests	_____		_____
<input type="checkbox"/> Lab tests	_____		_____

PLEASE OBTAIN OLD MEDICAL RECORD AS FOLLOWS:

Approximate date, facility, segment of record needed

Consult other physician as per attached consult sheet. Please inform Clinic Anesthesiologist of completion.

OTHER ORDERS

1. _____

2. _____

3. _____

4. _____

DAY OF SURGERY ORDERS

LABORATORY	Diagnosis
<input type="checkbox"/> Fingertick glucose	_____
<input type="checkbox"/> Prottime/PTT	_____
<input type="checkbox"/> Potassium	_____
<input type="checkbox"/> Basic metabolic panel	_____
<input type="checkbox"/> _____	_____

OTHER DAY OF SURGERY ORDERS

1. _____

2. _____

3. _____

4. _____

5. _____

Anesthesiologist signature _____ **Date** _____ **Time** _____

Nurse signature _____ **Date** _____ **Time** _____



PRE-SURGICAL ASSESSMENT CLINIC ORDERS

MD ORDERS 03