

Name: _____
 DOB: _____ Age: _____ Sex: _____
 Acct#: _____ Religion: _____
 MR#: _____
 Attending MD: _____

PERSONAL INFORMATION		
NAME Last	First	Previous Last Name (if applicable)
Date of Birth	Preferred Contact Number	Alternate Contact Number
Date of admission	<input type="checkbox"/> ASU <input type="checkbox"/> ASU-23hr <input type="checkbox"/> AM Admit <input type="checkbox"/> Endo <input type="checkbox"/> Spec/Rad. <input type="checkbox"/> Ped ASU <input type="checkbox"/> C-section	
History & Physical(select one)	<input type="checkbox"/> by Surgeon <input type="checkbox"/> by NP in PST	
Consulting Physicians (first, last)	FAX Number	Telephone Number
1		
2		

MEDICATION ORDERS (Scan to Pharmacy on Admission) HT: _____ WT: _____ KG

IV N/S 0.9% NaCl @ 75 ml/hour upon Admission to ASU or IV _____ @ _____ ml/hr

ANTIBIOTICS & DOSAGE _____ (dose) IVPB - In OR prior to incision

For β-lactam allergy: Clindamycin _____ (dose) IVPB - in OR prior to incision

For + MRSA screen, MRSA risk or β-lactam allergy:
 Vancomycin _____ (dose) IVPB – initiate in ASU, complete 2hrs. prior to cut

Other meds: _____

Tests- Lab Tests can ALL be performed non-fasting. Please refer to reference sheet for ICD-9's

TEST	ICD 9(required)	TEST	ICD 9 (required)
<input type="checkbox"/> Urine pregnancy (required unless post menapausal x 12 months)		<input type="checkbox"/> Chest X-ray (see A)	
<input type="checkbox"/> Urinalysis		<input type="checkbox"/> EKG (see B)	
<input type="checkbox"/> CBC and differential		<input type="checkbox"/> MRSA nares screen	
<input type="checkbox"/> Basic metabolic panel		<input type="checkbox"/> ABG [Respiratory Services]	
Is pt. taking Coumadin, Aspirin, Plavix	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	If yes, please circle which medication	
<input type="checkbox"/> PT/INR/ (see C)		<input type="checkbox"/> O2 sat [“ ”]	
<input type="checkbox"/> aPTT (see C)		<input type="checkbox"/> Other	
<input type="checkbox"/> Type & Screen Only			
<input type="checkbox"/> Type, Screen and Cross-Match		# of UNITS _____	
**Has pt. been transfused, rec'd blood products or pregnant in last 3 mo.?	<input type="checkbox"/> NO <input type="checkbox"/> YES		

Procedure on Consent Form should read:

MD/NP Signature: _____ Name (print): _____ Date: _____

