North Shore LIJ Huntington Hospital

Pre-Surgical/Procedure Testing Physician Orders
OR Fax (631) 351-2696

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	☐ ASU ☐ ASU-23hr ☐ AM Admit ☐ Endo ☐ Spec/Rad. ☐ Ped ASU ☐ C-section	
History & Physical **(select one)**	☐ by Surgeon ☐ by NP in PST	
Consulting Physicians (first, last)	**FAX** Number	Telephone Number
1		
2		

MEDICATON ORDERS (Scan to Pharmacy on Admission) **HT: _____ WT: _____KG**
ALLERGIES:_____

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

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

1P0

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