OPERATIVE AND ANESTHESIA SCHEDULE REQUEST

(This Form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)

SERVICE	OR #	CASE ORDER #	SCHEDULED ☐	SPACE AVAILABLE ☐	URGENT ☐	EMERGENT ☐	DATE OF SURGERY

NAME (Last, First, MI)	FMP	SSN	STATUS	☐ VIP COMMENTS

DOB	AGE	SEX: MALE ☐ FEMALE ☐	PATIENT TYPE: APV ☐ APV OVERNIGHT ☐ DOSA ☐ IN PT ☐	WARD	ISOLATION CATAGORY

CPT CODE	PROCEDURE DESCRIPTION	ESTIMATED PROCEDURE TIME

PREOP DIAGNOSIS

STAFF SURGEON #1	STAFF SURGEON #2	PRI/RES SURGEON #1	PRI/RES SURGEON #2

FROZEN SECTION ☐ XRAY ☐ C-ARM ☐ CELL SAVER ☐ BLOOD REQUIRED ☐ ____ #OF UNITS

PATIENT POSITION

SUPINE ☐ PRONE ☐ LATERAL ☐ LITHOTOMY ☐

OTHER ☐ SPECIFY ____

INTRA-OP DRUGS

SPECIAL EQUIPMENT/INSTRUMENT SETS REQUIRED

GENERAL REMARKS AND NOTES

ANESTHESIA TYPE

GENERAL ☐ CHOICE ☐ MAC ☐ REGIONAL ☐

OTHER ☐ SPECIFY ____

ALLERGY ____

ANESTHESIA REMARKS/REQUESTS	POST OP DESTINATION: ICU ☐ PACU ☐	LATEX: No ☐ Yes ☐

MED/SURG PROBLEMS	PRE-AUTHORIZATION FOR NETWORK FACILITY: YES ☐ NO ☐

CIRCULATOR REMARKS

BY DIGITALLY SIGNING THIS DOCUMENT YOU ARE AGREEING TO VERIFICATION OF PATIENT INFORMATION IN CHCS

DATE of REQUEST	SCHEDULING PHYSICIAN SIGNATURE *(Once document is signed, fields can not be changed)*	PAGER