

OPERATIVE AND ANESTHESIA SCHEDULE REQUEST								
<i>(This Form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)</i>								
SERVICE	OR #	CASE ORDER #	SCHEDULED <input type="checkbox"/>	SPACE AVAILABLE <input type="checkbox"/>	URGENT <input type="checkbox"/>	EMERGENT <input type="checkbox"/>	DATE OF SURGERY	
NAME (Last, First, MI)		FMP	SSN		STATUS	<input type="checkbox"/> VIP COMMENTS		
DOB	AGE	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	PATIENT TYPE APV <input type="checkbox"/> APV OVERNIGHT <input type="checkbox"/> DOSA <input type="checkbox"/> IN PT <input type="checkbox"/>			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 <input type="checkbox"/>	XRAY <input type="checkbox"/>	C-ARM <input type="checkbox"/>	CELL SAVER <input type="checkbox"/>	BLOOD REQUIRED <input type="checkbox"/>	<input type="text"/> #OF UNITS			
PATIENT POSITION								
SUPINE <input type="checkbox"/>		PRONE <input type="checkbox"/>		LATERAL <input type="checkbox"/>		LITHOTOMY <input type="checkbox"/>		
OTHER <input type="checkbox"/>	SPECIFY <input type="text"/>							
INTRA-OP DRUGS								
SPECIAL EQUIPMENT/INSTRUMENT SETS REQUIRED								
GENERAL REMARKS AND NOTES								
ANESTHESIA TYPE						ALLERGY		
GENERAL <input type="checkbox"/>		CHOICE <input type="checkbox"/>		MAC <input type="checkbox"/>		REGIONAL <input type="checkbox"/>		
OTHER <input type="checkbox"/>	SPECIFY <input type="text"/>					<input type="text"/>		
ANESTHESIA REMARKS/REQUESTS				POST OP DESTINATION		LATEX		
				ICU <input type="checkbox"/> PACU <input type="checkbox"/>		No <input type="checkbox"/> Yes <input type="checkbox"/>		
MED/SURG PROBLEMS				PRE-AUTHORIZATION FOR NETWORK FACILITY				
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
CIRCULATOR REMARKS								
BY DIGITALLY SIGNING THIS DOCUMENT YOU ARE AGREEING TO VERIFICATION OF PATIENT INFORMATION IN CHCS								
DATE of REQUEST	SCHEDULING PHYSICIAN SIGNATURE <i>(Once document is signed, fields can not be changed)</i>					PAGER		