MANDATORY FIELDS IN CAPITAL LETTERS

Facility Use Only		
Hospital Chart #	**Waitlist Start Date**	**Booking ID #**

SECTION 1: SURGICAL BOOKING INFORMATION

PREFERRED FACILITY:	Date/Time of Surgery:	**POST-OP BED REQUIRED**	**ADMISSION TYPE**	
Date/Time of Admission:		☐ Critical Care ☐ Surgical Telemetry ☐ Observation ☐ Other:	☐ DS ☐ DAS/SDS ☐ IP __ days before surgery ☐ Other:	**Saskatoon-PAC Admission** ☐ DS_PAC ☐ PSDS

PATIENT LAST NAME	**FIRST NAME**	Middle Name	Responsibility for payment ☐ SK Health ☐ Self pay ☐ Other

HEALTH SERVICE NUMBER	**DATE OF BIRTH** (MM/DD/YYYY)	**SEX** ☐ M ☐ F ☐ X Preferred Pronoun ☐ He ☐ She ☐ They	**NOK/LEGAL GUARDIAN NAME**
PERMANENT ADDRESS	**CITY OR TOWN**	**PROVINCE** **POSTAL CODE**	**PHONE #** (if different from patient)

PRIMARY PHONE #	Alternate Phone #	Day Before Surgery Phone #	e-mail

REFERRING PHYSICIAN	**REFERRING DATE** (MM/DD/YYYY)	**FIRST CONSULT DATE** (MM/DD/YYYY)	Family Physician

DIAGNOSIS CODE	**DIAGNOSIS DESCRIPTION** (Enter free text if using "other" Dx Code)	**PRIORITY** ☐ ☐ ☐ ☐ ☐ **1 2 3 4 5**	**PROVEN OR SUSPECTED CANCER** ☐ Yes ☐ No

Pre-op diagnosis:

SURGEON	**PROCEDURE**	**LATERALITY:**	**SITE:**
1			
2			
3			
Assistant Required: ☐ Yes ☐ No	Assistant Name:	**EST. PROCEDURE TIME**:	

TIME UNAVAILABLE DATES WERE DISCUSSED WITH PATIENT ☐ Yes ☐ No	Unavailable from:	Unavailable to:	Reason:	**AVAILABLE SHORT NOTICE (1-5 DAYS)** ☐ Yes ☐ No

Preferred anesthetic: ☐ General ☐ Spinal/Epidural ☐ Retrobulbar ☐ Local ☐ Topical ☐ MAC ☐ Regional ☐ None

Alerts/Additional Conditions: ☐ None required

☐ Advance Directive ☐ ARO (_____) ☐ BMI over 40

☐ Malignant hyperthermia ☐ Diabetes Type 1 ☐ Diabetes Type 2 ___IDDM ___ NIDDM

☐ Previous complications:

☐ Other:

OPERATING ROOM NEEDS ☐ Bariatric Equipment ☐ C-arm (Fluoro)

☐ Items/Equipment/Loaner sets:

Allergies: ☐ None known

☐ Latex Allergy

☐ Metal Allergy

☐ Other:

SURGEON SIGNATURE

***** For All Pre-Op Physician Orders, including labs, imaging and consults, refer to page 2 *****

SECTION 2: PHYSICIAN ORDERS

Consultations: ☐ None required

☐ Internist, date/time:
☐ Anesthesia, date/time:
☐ Occupational Therapy
☐ Physical Therapy
☐ Home care
☐ Other:

PAC: ☐ None required

Date/Time:
1.

2.

Appointment ____ days before surgery
☐ Doctor
☐ Nurse
☐ Phone
☐ Virtual

Medical Imaging: ☐ None required

☐ X-ray ☐ MRI ☐ CT Scan
☐ Pre-admission Chest
☐ Other

Images/films required in OR? ☐ Yes ☐ No

Medications held for surgery: ☐ None

Stop ___ days prior to surgery

Laboratory: ☐ None required

☐ Electrolytes
☐ Chemscreen
☐ CBC
☐ Group & Screen
☐ Urinalysis
☐ PFT
☐ Quick/Frozen Section
☐ Glucose Spot
☐ Cardiac Blood Work

☐ PT/PTT/INR
☐ Cross Match __ Units
☐ Autologous __ Units
☐ Urine C & S
☐ ABG
☐ LFT
☐ Urea/Creatinine
☐ Renal
☐ ECG

Pregnancy Test
☐ Serum
☐ Urine
☐ Other

☐ Reorder lab work if greater than 90 days

Other Medications:

Pre-printed order attached? ☐ Yes ☐ No

Surgeon Signature: