



SURGICAL RESERVATION FORM/PHYSICIAN'S ORDERS

1044 North Francisco Avenue, Chicago, Illinois 60622

The following information is **REQUIRED**. The reservation will not be completed without this information.

PLEASE FAX COMPLETED FORM TO: (773) 278-8872

Patient Name: _____ MR # _____
(If known)

Sex: Male Female Date of Birth: _____

Home ph: _____ Cell ph: _____ Work ph: _____

Address: _____

Primary Insurance: _____ Policy # ID: _____

Requested Surgery date: _____ Requested Time: _____ Case duration: _____

Patient Type: Outpatient Inpatient Admit post-op 23^o Observation

Pre-Op Diagnosis: _____

Procedure: _____

Procedure CPT Code: _____ Anesthesia: Local Mac Gen Spinal
 Regional Others: _____

Implants needed? Yes No Implant system: _____

Hospital Transportation needed? Yes No Interpreter needed? Yes No
Language? _____

Were pre-op labs done? Yes No If yes, where? _____

LABORATORY

PHYSICAL THERAPY

- CBC
- Hemoglobin & Hemocrit
- Urinalysis
- Pregnancy Serum
- Pregnancy urine (BHCG)
- Other (Specify) _____
- PT/a PTT
- CMP
- Potassium level
- Type & Screen

- Pre-op gait training with assistive device
- Full weight bearing
- Weight bearing as tolerated
- Partial weight bearing
- Toe touch weight bearing
- Non weight bearing
- Cane
- Crutches
- Walker

CARDIOLOGY

DIAGNOSTIC IMAGING

- EKG
- Chest Xray
- Other (Specify) _____

Physician's Printed Name

Nurse Signature
(AUTHENTICATION OF VERBAL OR TELEPHONE ORDERS)

Physician's Signature

Date/Time