



SURGERY SCHEDULING/PHYSICIAN ORDER FORM

- TOWNSEN MEMORIAL HOSPITAL – HUMBLE Office: 281-369-9001 Return via fax: 866-499-1008
- TOWNSEN MEMORIAL SURGERY CENTER – SPRING Office: 346-386-6700 Return via fax: 346-386-6701
- TOWNSEN MEMORIAL SURGERY CENTER – KINGWOOD Office: 713-243-3548 Return via fax: 866-539-8631
- TOWNSEN MEMORIAL SURGERY CENTER - MED CENTER Office: 346-200-9400 Return via fax: 346-200-9499

Surgeon: _____ Asst Surgeon: _____

Surgery Date/Time: _____ Duration of Procedure: _____

Type of Service (Mark one): INPATIENT (HOSPITAL ONLY, estimated length of stay _____) OUTPATIENT

Patient Name: _____ DOB: _____ Contact Phone #'s: _____

Pre-op Diagnosis: _____ ICD: _____

Procedure/Consent: _____

_____ CPT Code(s): _____

Cell Saver (Mark one): YES NO Neuromonitoring (Mark one): YES NO

C-Arm Required (Mark one): YES NO C-Arm Size (Mark one): LARGE SMALL

Special Equipment/Implants: _____ Rep: _____

Operative Position: PRONE SUPINE BEAN BAG LATERAL DECUBITUS

Operative Table: JACKSON WILSON FRAME REGULAR BEACH CHAIR MAYFIELD

Inpatient Physical Therapy required? YES NO

Type of Anesthesia	<input type="checkbox"/> General <input type="checkbox"/> MAC <input type="checkbox"/> Local <input type="checkbox"/> TIVA <input type="checkbox"/> Other:					
Nerve Block	<input type="checkbox"/> YES <input type="checkbox"/> NO		Type:			
Diet	<input type="checkbox"/> NPO after Midnight		<input type="checkbox"/> Other:			
Labs	<input type="checkbox"/> CBC	<input type="checkbox"/> CMP	<input type="checkbox"/> BMP	<input type="checkbox"/> PT/INR	<input type="checkbox"/> PTT	<input type="checkbox"/> U/A
	<input type="checkbox"/> LIPID PANEL	<input type="checkbox"/> HbA1C	<input type="checkbox"/> 1 Stat ABG			
	<input type="checkbox"/> Type & Cross _____		Units PRBC			
	<input type="checkbox"/> Other:					
Diagnostics	<input type="checkbox"/> EKG <input type="checkbox"/> CXR					
Circulation Devices	<input type="checkbox"/> Ted hose <input type="checkbox"/> SCD's					
DME Needed	<input type="checkbox"/> YES <input type="checkbox"/> NO		Provided by:		<input type="checkbox"/> Surgeon <input type="checkbox"/> Hospital	
	Equipment Needed:					
Surgeon Clearance Requests	<input type="checkbox"/> Medical Clearance		<input type="checkbox"/> Cardiology Clearance		<input type="checkbox"/> Per Anesthesia Request	
	By patient's PCP		By patient's cardiologist			
Allergies				I.V.F.: <input type="checkbox"/> LR @ 30mL/hr <input type="checkbox"/> NS @ 30 mL/hr		
Medications	<input type="checkbox"/> Levofloxacin (Levaquin) 500mg IVPB			<input type="checkbox"/> Levofloxacin (Levaquin) 750mg IVPB		
	<input type="checkbox"/> Cefazolin (Ancef) 2G IVPB			<input type="checkbox"/> Cefazolin (Ancef) 1G IVPB		
	<input type="checkbox"/> Clindamycin 600mg IVPB			<input type="checkbox"/> Other:		
	<input type="checkbox"/> Other:					

Physician Signature: _____ Date: _____ Time: _____