PRESURGICAL SCHEDULING REQUEST/ORDERS
TORRANCE MEMORIAL MEDICAL CENTER

Surgery Scheduling: (310) 517-4690 Surgery Scheduling Fax: (310) 784-8783 PAS: (310) 517-4643

☐ Check if this is an update to a currently scheduled case

SURGICAL INFORMATION: Date Submitted:

Requested Procedure Date:	Requested Procedure Start Time:
Requested Length of Procedure:	Surgeon:
Assistant Surgeon:	Primary Care Physician:

Requested Procedure(s):

Special Equipment/Requests:

☐ Representative Required ☐ Representative Needed to Start Case

Type of Anesthesia: ☐ General ☐ Regional ☐ MAC ☐ Local

Pre-Op Diagnosis: Latex Allergy: ☐ Yes ☐ No

Patient Admission Type: ☐ IP ☐ DS ☐ SHORT STAY ☐ Floor

PATIENT DEMOGRAPHIC INFORMATION:

Patient Name:		DOB:
Sex: ☐ Male ☐ Female	SSN:	
Address:	Home #:	Work #:
	Cell #:	Other #:

Insurance Name: Member Name:

Group: ID: Insurance Authorization Number:

CPT 4 Code: ICD-9 Code:

Name of Person Completing Document: Phone #: Fax #:

To be Completed by TMMC Surgery Scheduling:

Confirmation Code:	OR Date:	OR Time:

Requested PAT Appointment Date: Time:

ORDERS: ☐ PREOP TESTING PER ANESTHESIA PROTOCOL (OR COMPLETE THE SECTION BELOW)

LABORATORY TEST: ALL TESTS REQUIRE CLINICAL INDICATION/MEDICAL NECESSITY

Testing must be done at TMMC laboratory no more than 7 to 10 days prior to surgery if not completed at outside facility.

☐ EKG: _____ ☐ Basic Metabolic Panel: _____

☐ Chest X-Ray: _____ ☐ UA: _____ ☐ C&S: _____

☐ CBC: _____ ☐ Protime/PTT: _____

☐ Cardiac Surgery Profile: ☐ Other:

BLOOD BANK ORDERS (if required):

☐ Type and Screen (includes blood type and antibody screen) No more than 72 hours prior to surgery

☐ Crossmatch _____ units of RBCs (includes type and screen, autologous and/or directed donor units if available.)

☐ _____ units Fresh Frozen Plasma ☐ _____ units Plateletpheresis ☐ _____ units Cryoprecipitate

Specific Orders for RHEV Evaluation (includes blood type, RH Immune Globulin dose prepared if RH negative):

☐ Include Antibody Screen ☐ Blood Type Only

_____ _____ A.M./P.M. _____

[Date] [Time] Physician Signature Required /Print Name & Dictation #

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Patient Identification

04/10

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