PLACE PATIENT
LABEL
CAREFULLY HERE

UNIVERSITY HOSPITAL
MCDUFFIE

SERVICE ORDER FORM Standard Pre-Operative/Pre-Procedure Orders

Fax (706) 597-5144

Admission Priority: ☐ Emergency ☐ Urgent ☐ Elective **TYPE OF ADMISSION:** ☐ INPATIENT ☐ OUTPATIENT

Medical Justification (Include onset of illness date) Reason for Admission prior to procedure: _____

Location: ☐ SCC ☐ Other: _____ Surgery Case Confirmation Number: _____

Allergies: Height: Weight:

Last Name _____ First _____ MI _____ Sex: M F

DOB___/___/___ Attending Physician _____ Medical Record # _____

Insurance;Primary _____ Policy/GRP# _____ Pre-Cert# _____

Insurance;Secondary _____ Policy/GRP# _____ Pre-Cert# _____

☐ No Tests Required ☐ Ordered Test Below ☐ History & Physical ☐ Dictated ☐ Sent with Patient ☐ Consent Sent with Patient ☐ No Consent

****ATTACH OR FAX A COPY OF DEMOGRAPHIC/INSURANCE INFORMATION****

PLEASE CHECK THE APPROPRIATE BOX - ☐ ROUTINE ☐ STAT ☐ TO BE SCHEDULED

DIAGNOSTIC TEST/PROCEDURE NAME	CPT	ICD-10 & DIAGNOSIS	READING PHYSICIAN
1.			
Clinical Decision Support Vendor utilized; (qCDSM) ☐ NA Name; _____ or Code; G_____	Decision Support Session ID # _____ Score_____ Adherence; ☐ MF(no) ☐ MG(no criteria avail.) ☐ ME(yes)		
2.			
Clinical Decision Support Vendor utilized; (qCDSM) ☐ NA Name; _____ or Code; G_____	Decision Support Session ID # _____ Score_____ Adherence; ☐ MF(no) ☐ MG(no criteria avail.) ☐ ME(yes)		
3.			
Clinical Decision Support Vendor utilized; (qCDSM) ☐ NA Name; _____ or Code; G_____	Decision Support Session ID # _____ Score_____ Adherence; ☐ MF(no) ☐ MG(no criteria avail.) ☐ ME(yes)		

TEST ICD-10 Code	TEST ICD-10 Code	BLOOD BANK ICD-10 Code	TEST ICD-10 Code
☐ BLOOD COUNT _____ ☐ PLATELET _____ ☐ DIFF _____ ☐ BMP _____ ☐ CMP _____ ☐ PRIOR LABS ARE ATTACHED ☐ NEW LAB ORDERS ATTACHED	☐ ESR _____ ☐ CRP _____ ☐ U/A Microscopic _____ - Reflux Culture ☐ Pre – Op Nasal Screen _____ ☐ BETA HCG _____ ☐ PT / INR ☐ PTT _____	☐ TYPE AND SCREEN ONLY _____ ☐ TYPE AND CROSSMATCH NUMBER OF UNITS _____ ☐ AUTOLOGOUS _____ ☐ DIRECTED/ DESIGNATED _____	☐ EKG Read by Dr._____ ☐ PRIOR CARDIAC CLEARANCE by Dr. _____ ☐ PRIOR EKG DONE Date: _____ by Dr. _____

Pre-Op Visit Date: _____ For Surgery patients, use Anesthesiologist's Standard Pre-op Orders

☐ If patient has history of MRSA or if nasal screen is positive, activate the Staph aureus MRSA Pre-op Decolonization Order Set.

Pre-op Medication(s) Dose Route Frequency

1. _____

2. _____

***note: Pre-op antibiotics must be entered in Epic by the provider to ensure appropriate antibiotic selection**

☐ VO ☐ TO RBAV _____ / _____

Physician's Signature: _____ _____

(Date) *required (Time)