

**Regional One Health Surgery Center**

**Physician's Order Sheet**

Patient's Name \_\_\_\_\_

Patient's DOB \_\_\_\_\_

Allergies: \_\_\_\_\_

Physician's Order Date:		
Procedure:		
Diagnosis:		
CPT Code:	Diagnosis Code:	
Operative Site:		
Positioning:	SCD Boots: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Anesthesia:	<input type="checkbox"/> General	<input type="checkbox"/> MAC <input type="checkbox"/> Local <input type="checkbox"/> Regional
Estimated Procedure Duration:		
Preoperative antibiotic to be given in operating suite less than 1 hour prior to incision:		
Special Instructions/Items Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain:		
Pre-admission tests: <input type="checkbox"/> ECG <input type="checkbox"/> CXR <input type="checkbox"/> BMP <input type="checkbox"/> CBC <input type="checkbox"/> PT/aPTT <input type="checkbox"/> Type and Screen <input type="checkbox"/> Other: _____		
Note: HCG and blood glucose will be completed immediately prior to surgery as required per OSC admission criteria.		
Post Op Appointment (written as days after surgery):		
Ordering Physician:	Attending Approval:	
Attending Physician Signature:	Date:	Time:

**Note: Scheduling requires advance approval from attending physician.  
Attending physician signature must be provided within 24 hours of scheduling.**

**Fax to (901) 515-3997**