

Patient Name: _____ DOB: _____ MRUN: _____
 SS#: _____ Home Phone: _____ Work Phone: _____ Best Time to Call: _____
 Medicare Self Pay Indigent Expiration Date _____
 TennCare (type): _____ Insurance (type) _____
 Prior Approval # _____ Given By: _____
 Authorization Obtained By: _____
 PAT Schedule Date/Time: _____ 1st Post-op visit appointment _____

Surgical Admission Orders - Eye Surgery

Date of Surgery/Procedure: _____ Requested Time: _____
 Admission Status: SDS INPATIENT (EMA) Admitting Physician: _____
 Admitting Diagnosis: _____
 Admitting/Procedure Codes: _____
 Consent/Permit for: _____
 Right Left Bilateral N/A
 Special Equipment: _____

Two weeks prior to surgery, schedule the following:

- Clinic visit for H & P Social Service Consult
 PAT (Pre-Admission Testing/Hospital)

Pre Op Orders

Diagnosis/Reason for Tests: _____

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> PVC | <input type="checkbox"/> PT / PTT | <input type="checkbox"/> U / A | <input type="checkbox"/> EKG |
| <input type="checkbox"/> CBC | <input type="checkbox"/> Sed Rate | <input type="checkbox"/> Urine Pregnancy Test | <input type="checkbox"/> Chest X-ray |
| <input type="checkbox"/> CBC with Differential | <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> BMP | <input type="checkbox"/> Type and Screen | <input type="checkbox"/> NPO after midnight | |
| <input type="checkbox"/> CMP | <input type="checkbox"/> Cross match _____ | # of units _____ | |

Allergies: _____

Orders for Eye Surgery - Day of Surgery

- Medication(s) to be given day of surgery: _____
 Pre-Op drops in _____ eye; use 1 drop of each X3 separated by 5 - 10 minutes
 Tropicamide 1% gtt Phenylephrine 2.5% gtt Establish NS IV lock access
 Cyclopentolate 1% gtt Flurbiprofen Na
 Proparacaine 0.5% gtt

LENS POWER: SN60 _____ MA60 _____ MTA4 _____

Physician Signature: _____ Date: _____ Time: _____

Pre-Admission Testing Staff: If a Type and Screen is ordered, the following must be asked to the patient:

- Have you had a blood transfusion in the last 3 months? Yes No Not Applicable
 Have you been pregnant in the last 3 months? Yes No Not Applicable
 Are you currently pregnant? Yes No Not Applicable
 Signature of Staff asking questions: _____ Date: _____ Time: _____ am / pm

* 647.019 *

Place Patient Label Here