Nashville General Hospital at Meharry 1818 Albion Street, Nashville, TN 37208

Pre Admission Testing Center
Phone: 615-341-4285 Fax: 615-528-3621

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 appointment** __________

Surgical Admission Orders-Orthopedic

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/Implants/Graft Required: __________ **Specify Site: Harvest** __________ **Donor** __________
☐ **C-Arm** ☐ **Cell Saver** ☐ **Sales Rep Needed: Name** __________ **Contact #** __________

Two weeks prior to surgery, schedule the following:

☐ **Clinic visit for H & P**
☐ **PAT (Pre-Admission Testing/Hospital)**
☐ **Social Service Consult**
☐ **PT Consult for Pre op Teaching**

Pre Op Orders

Diagnosis/Reason for Tests: __________

☐ **CBC**	☐ **Cross Match** __________	__________ **# of units** __________
☐ **CMP**	☐ **EKG > 40 years**	
☐ **PT / PTT**	☐ **Chest X-ray > 60 years**	☐ **Other:** __________
☐ **Type & Screen**	☐ **Urine Pregnancy Test**	☐ **Other:** __________
☐ **U / A**	**Other:** __________	☐ **Other:** __________

Day of Surgery Orders

Allergies: __________
Antibiotic: (for severe PCN allergies, use non-cephalosporin)

☐ **Cefazolin** ☐ **1 gm IV** ☐ **2gm IV**
☐ **Vancomycin (for MRSA, to be started 2 hours prior to surgery)** ☐ **1 gm IV** ☐ __________
☐ **No Antibiotics**
☐ **Other:** __________

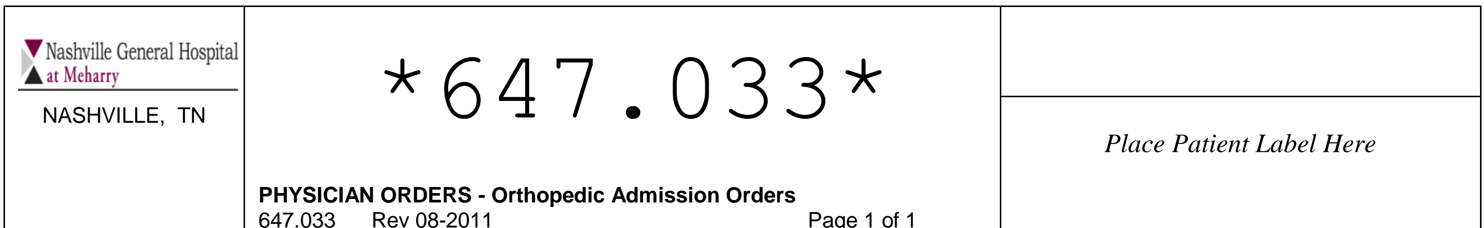
☐ **Heparin 5000 units sub Q** ☐ **IVF LR @** ______ **ml/hr** ☐ **IVF NS @** ______ **ml/hr**
☐ **Foot Pump to Opposite Limb** ☐ **TED Hose (to opposite limb)** ☐ **NPO after midnight**
☐ **Shower 10 minutes with Chlorhexidine (Attention to Operative Area)** ☐ **SCD's**

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**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NASHVILLE, TN

647.033

PHYSICIAN ORDERS - Orthopedic Admission Orders
647.033 Rev 08-2011 Page 1 of 1

Place Patient Label Here