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 Time:________________

Surgical Admission Orders

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**
☐ **CBC with Differential**
☐ **ABG**
☐ **CMP**

☐ **PT / PTT**
☐ **Sed Rate**
☐ **Hepatic Panel**
☐ **Type and Screen**
Cross match ________

☐ **U / A**
☐ **Urine Drug Screen**
☐ **Urine Pregnancy Test**
☐ **Other:**________
________ **# of units** ________

☐ **EKG > 40 years**
☐ **EKG**
Reason: ________
☐ **Chest X-ray > 60 years**
☐ **Chest X-ray**
Reason: ________
☐ **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** ☐ ________
☐ **Other:** ________________ **Amount:**________

☐ **Heparin 5000 units subQ** ☐ **IVF LR @** ______**ml/hr** ☐ **IVF NS @** ______**ml/hr**
☐ **SCD's** ☐ **TED Hose (thigh high)** ☐ **NPO after midnight**

Physician Signature: ________________ ***Date:***________ ***Time:***________
Office/Clinic: ________________ ***Phone:*** ________ ***Fax:*** ________

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**