

| PATIENT LABEL |  |  |
|---------------|--|--|
|               |  |  |
|               |  |  |
|               |  |  |
|               |  |  |

## PRE-SURGICAL PHYSICIAN ORDERS TOTAL JOINT SURGERIES-FOR TOTAL JOINT PATIENTS ONLY

| <b>Northwestern Medic</b><br>Phone: 815.759.4902<br>Fax: 847.802.7403                               | -               | lospital           | ☐ Out       | nit Post-op Surgical<br>patient Surgical<br>patient Surgical-Same Day |  |   |               |                |  |
|---|-----------------|--------------------|-------------|---|--|---|---------------|----------------|--|
| Patient Name  |                 |                    |             |   | DOB  |   | <i>F</i>      |                |  |
| If minor, parent/guard  | dian name       |                    |             |   |  | ☐ Male [  | ☐ Female      | ☐ X-gender     |  |
| Home phone  |                 |                    |             |   |  |   |               |                |  |
| Street address  |                 |                    |             |   |  |   |               |                |  |
| Surgeon   |                 |                    |             |   |  |   |               |                |  |
| Primary care physicia   |                 |                    |             |   |  |   |               |                |  |
| H&P done by   |                 |                    |             |   |  |   |               | Yes 🗆 No       |  |
| H&P completed by PC   |                 |                    |             |   |  | _   |               |                |  |
| Admitting diagnosis _ Permit to read  |                 |                    |             | ICD-10  | 0 Code   | CP  | T Code        |                |  |
| Surgery date Time  PRE-SURGICAL TESTING Surgical or  Pre-surgical orders according to anesthesia gu |                 |                    | ical orders | received:   | Anesthesia  Sciatic r Poplitea Anesthesia Single s | sia:  General  Spinal  Choice sia type:  Femoral nerve block c nerve block  Adductor canal block teal nerve block  IPACK block sia consult for: e shot  Continuous catheter Initials: |               |                |  |
| ADDITIONAL TEST   | S (ICD-10 Co    |                    | <del></del> |   | nuto substitute                                    | ed for Total Kne  | ee Arthroplas | ty procedures. |  |
|   | Ordered         | ICD-10             | Completed   |   |  | Ordered   |               | Completed      |  |
| CBC w/Diff  |                 | Z01.812            |             | EKG   |  |   | Z01.810       |                |  |
| Lytes   |                 | Z01.812            |             | Chest X-ra  | _  |   | Z01.810       |                |  |
| BMP   |                 | Z01.812            |             | ¹Clot to Ho   | • • •  |   |               |                |  |
| CMP   |                 | Z01.812            |             | Type & Screen (THA)  -On Admit  |  |   |               |                |  |
| HCG (qual) Urinalysis   |                 | Z01.812<br>Z01.812 |             | MRSA Swab   |  |   |               |                |  |
| Pro Time  |                 | 201.012            |             | Spirometry  |  |   |               |                |  |
| PTT   |                 |                    |             | Dobutamir   |  |   |               |                |  |
| Thyroid Cascade   |                 |                    |             | Lexiscan s  |  |   |               |                |  |
| Hemoglobin A1C  |                 |                    |             | COMISCUITS  |  |   |               |                |  |
| Draw 1 extra tiger to   | p tube (protect | from light)        |             |   |  |   |               |                |  |



| Patient Na     | ent Name: DOB:           |  |  |   |               |            |
|----------------|--------------------------|--|--|---|---------------|------------|
| ADDITIONA      | AL ORDERS                |  |  |   |               |            |
| ALLERGIES      |                          |  |  |   |               |            |
| Height         | We                       | ight   | 🗆 Latex allergy                                  | OR special equip  | ment need     | ls:        |
| History of:    | ☐ MRSA ☐                 | VRE □ C. d                                     | iff  |   |               |            |
| □ Sequent      | ial stockings:           | $\square$ Knee high                            | ☐ Thigh high                                     |   |               |            |
|                | t <b>ings:</b> ☐ Knee    | high 🗌 Thi                                     | igh high   |   |               |            |
| ☐ AE boots     |                          |  |  |   |               |            |
| 1 -            | TKA Peri-oper            |  |  | Additional orders   | ) <b>:</b>    |            |
| 1 -            |                          |  | otic Hospital Protocol (procedure)               |   |               |            |
| IV: LR, 1L, T  |                          |  | (procedure)                                      |   |               |            |
|                |                          |  |  |   |               |            |
|                | length of case:          |  | <del></del>                                      | _   |               |            |
| Instruct pa    | tient to: 3 day          | ys prior to su                                 | <b>irgery-</b> Shower or bathe wi                | ith 4% chlorhexidine  | gluconate     | e soap.    |
|                | Day o                    | of surgery-A                                   | apply 2% chlorhexidine glud                      | onate to surgical si  | te prior to p | orocedure. |
|                |                          |  | ed with scheduling:<br>device such as LVAD, ECMC | ), IABP, IMPELLA?   | ] Yes 🔲 N     | 0          |
| Time           | Date                     | <b>Telephone Order Given By</b> (Please Print) |  | <b>Telephone Order Received By</b> (Please print/sign/verify read back) |               |            |
| Physician's N  | <b>Name</b> (Please Prir | nt)  |  |   |               |            |
| Time           | Date                     | F  | Physician's Signature                            |   |               |            |
| Insurance li   | nformation               |  |  |   |               |            |
| Insurance nan  | ne                       |  | F  | Phone number (  | )             |            |
|                | me                       |  |  |   |               |            |
|                | Last nar                 | me   | First name                                       | Mid   | ddle initial  |            |
| ID #           |                          |  | Group #  |   |               |            |
| Workers' Co    | ompensation              |  |  |   |               |            |
| Employer nam   | ne                       |  |  |   |               |            |
| Date of injury | '                        | Cla  | aim number                                       |   |               |            |
| Adjuster Cont  | act Information:         |  |  |   |               |            |
| Name           |                          |  | Email  |   |               |            |
| Phone numbe    | er_( )                   |  |  | er ( )  |               |            |
| Claim address  | S                        |  |  |   |               |            |
|                | Street or P              | O Box  | City   |   | State         | ZIP        |

Please provide a front and back copy of the insurance card.