PLEASE LEGIBLY COMPLETE THIS FORM *NURSE'S NAME* _____

SURGERY FORM

DOCTORS: DASA DI MARTINO DUGAS GORMAN HARTMAN KRAUSE MARRERO (circle one)

PATIENT NAME:_____CHART #_____DOB_____

HOSPITAL_____DATE OF SURGERY_____TIME_____

NUMBER OF DAYS IN HOSP:_____ TYPE OF ADMIT: AM ADMIT_____OUT PT_____23HR_____

PROCEDURE:_____

_____

_____CPT_____

DX:_____ICD9_____

TYPE OF ANESTHESIA_____ANESTHESIA CONSULT: YES__ NO__

ASSISTANT MD_____DATE & TIME OF APPT._____

EQUIPMENT FOR SURGERY:_____

_____

_____

BioMet☐ Stryker☐ Zimmer☐ Depuy☐ Arthrex☐ syntes☐ Smith & Nephew☐
Wright Medical☐ Acu Med☐

JOINT CAMP_____PRE-OP PT APPT_____POST-OP PATIENT APPT:_____

CPM:_____SSEP_____CELL SAVE_____TABLE_____POSTION_____ICU POSTOP_____

OEC C-ARM_____NAVIGATION_____BIL LE DOPPLER_____

LABS: CBC CHEM20 BMP PT/PTT ALB/PREALB ESR CRP UA UAC&S UPT CXR EKG

TYPE & CROSS_____AUTOLOGOUS_____ # OF UNITS_____

MEDICAL CLEARANCE: YES____ NO____ DOCTOR_____ _____

DATE & NAME OF OR CONTACT:_____CONFIRMATION#:_____

INSURANCE CO/PRE CERT#:_____

_____

_____

CONSENTS:_____ HIP TO ANKLE X-RAY_____ _____

NOTES: