Cabell Huntington Hospital

Surgical Services
Initial Perioperative Testing

Directions: 1. Indicate choice when options are available by placing a check in the box ☑
2. Mark through entire line any prechecked item you ***do not*** wish to order ~~☑ mark through~~

☐AM Admission ☐Outpatient Surgery ☐Surgery Date:_____ ☐Arrival Time: _____

Surgical Procedure:

Attending Physician: Diagnosis:

Age: _____ Birthdate: _____

ALLERGIES: ☐NKA **ALLERGIC to:**

PRIOR TO SURGERY: Preop testing unnecessary for most healthy patients: ALL ordered test must include indication, if indication not listed, document below

LABORATORY:

☐ **CBC** w/Diff, indication: ☐history of blood loss ☐anemia ☐hematologic symptoms/disease ☐Other_____

Order Beta HCG on all females: onset mensus through age 50 (except previous hysterectomy/tubal ligation):

☐ **Beta HCG** (within 7 days of surgery), indication: possible pregnancy

☐ **Beta HCG Urine** (within 7 days of surgery), indication: possible pregnancy

☐ **BMP,** indication: ☐congestive heart failure (CHF) ☐renal insufficiency ☐diuretic therapy ☐digoxin ☐angiotension receptor blockers (ARB) ☐ (ACE) inhibitors ☐Other_____

☐ **PT/INR**, indication: ☐chronic liver disease ☐malnutrition ☐history of bleeding tendencies ☐anticoagulant therapy (example: **Coumadin**) ☐Other_____

☐ **PFA**, indication:☐scheduled to receive regional anesthesia ☐on high dose ASA (325 mg or greater) ☐history of sickle cell anemia ☐on Plavix/Ticlid ☐Other_____

☐ **aPTT**, indication: ☐anticoagulant therapy (within past 5 days) (example: **Heparin**) ☐Other_____

☐ **Type and Screen**, indication: surgery with anticipated significant blood loss

☐ **Crossmatch** x _____ units, indication: surgery with anticipated significant blood loss (if blood products within the past 3 months, type and crossmatch)

☐ **Urinalysis**,(C&S if indicated) indication: dysuria ☐Other_____

☐ **CCP**, indication: ☐liver disease ☐nephropathy ☐enteropathy ☐recent severe illness ☐diabetes mellitus ☐hypertension ☐renal insufficiency ☐Other_____

RADIOLOGY:

☐ **Chest PA and lat**, indication: ☐known cardiac/pulmonary disease (if greater than 1 year since last chest xray) ☐physical examination findings of cardiopulmonary disease exacerbation ☐wheezing ☐cough ☐other: _____

CARDIOLOGY:

☐ **EKG**, indication: ☐cardiovascular symptoms/disease ☐Other_____
☐two or more risk factors (circle): smoking obesity diabetes hypercholesterolemia

ADDITIONAL ORDERS:

Physician/Provider Pager Date___/___/___Time:____

☐ Verbal Order Verification Signature Date___/___/___Time:____

Patient Identification