Pediatric Surgical and Procedural Scheduling Form

Scheduling office: t 512-324-0126 | **fax** 512-370-5527

All fields must be filled out completely and accurately.

Surgery case information

Surgery/procedure date ________ **Hospital** ________ **Preferred start time** ________

Primary surgeon/ordering MD ________ **Contact number** ________

Co-case/Assisting surgeon (circle one) ________

If co-case, 1st operating physician ________ 2nd operating physician ________

Procedure(s) *(as to appear on consent)* ________

____

Procedure length ________ *(give only your estimated time)* **CPT code(s)** ________

Equipment needed ________

____

PreOp diagnosis(es) ________ **ICD-10 code(s)** ________

Anesthesia: ❑ Gen ❑ Local ❑ Anes Choice ❑ Mac ❑ Other ❑ None

Additional comments: ________

(i.e. implants, risks, impaired mobility, comments, etc.) **If implants are needed, please be specific.**

Service status: ❑ OutPt ❑ OutPt/reserve room ❑ TBA ❑ InPt (Room #) ________ PreOp visit required? ❑ Y ❑ N

Admit after surgery to PICU/NICU/IMC for ________ days (reservation made by MD office) Admit after surgery for ________ days

Patient demographics

Primary language if other than English ________

Medical record # ________ **Legal name** (last) ________ (first) ________ (MI) ________

Street address ________ **City** ________ **State** ________ **Zip** ________

Date of birth ________ ❑ male ❑ female **Social Security#** ________ - ________ - ________

Phone (H) ________ (W) ________ (ext.) ________ (C) ________

Ht: ________ **Wt:** ________ **kg** **Allergies and reactions:** ________

Alternative contact person name ________ Relationship to patient ________

Contact phone (H) ________ (W) ________ (ext.) ________ (C) ________

Authorization to leave messages on patient answering system? ❑ Y ❑ N

Insurance Information

Primary insurance carrier ________ **Insurance identification #** ________

Referral/Auth/Precert # ________ **Effective date** ________

Secondary insurance carrier ________ Insurance identification # ________

Referral/Auth/Precert # ________

Physician Orders/Medication/DVT Orders

Lab/EKG/Rad ordered *(please specify)*

Lab draw location: ❑ Pre-op ❑ Intra-op ❑ CPL (done) ❑ Apply SCD's H&P ❑ MD to Bring ❑ Dictated ❑ Faxed ❑ Day of Surgery

❑ Other ________ (________ mg/kg) ________ mg dose

Office scheduler ________

Physician signature ________ Time ________ Date ________

***Requires original signature*

All fields must be filled out completely and accurately.

Patient demographics

Medical Record # ________________ **Legal Name** (last) ______________________________ (first) ______________________ (MI) ______

Preop IV antibiotic orders

❑ Pharmacy to dose optimize per Pediatric P&T approved Antibiotic Surgical Prophylaxis policy.
❑ No Pre-Op antibiotic(s)

Procedure	Preferred Antibiotic	Alternative for B-Lactam Allergy
Cardiothoracic		
-Cardiac surgery -Non-cardiac thoracic procedures	❑ Cefazolin	❑ Vancomycin
General Surgery		
-Gastroduodenal -Esophageal -Small intestine – non-obstructed -Biliary Tract -Gynecologic	❑ Cefazolin	❑ Clindamycin **PLUS/MINUS** ❑ Gentamicin
-Colorectal -Small intestine - obstructed	❑ Cefazolin **PLUS** Metronidazole	❑ Metronidazole **PLUS** ❑ Gentamicin
-Appendectomy -Pelvic Inflammatory Diseases with or without tubovarian abscess	❑ Ceftriaxone **OR** Cefazolin, if incision greater than 60 minutes from ceftriaxone dose **PLUS** Metronidazole	❑ Metronidazole **PLUS** Gentamicin
Head and neck/plastic surgery		
Head and neck/plastic surgery	❑ Cefazolin **OR** ❑ Ampicillin-sulbactam **OR** ❑ Cefazolin **PLUS** Metronidazole	❑ Clindamycin Neurosurgery
Neurosurgery		
Neurosurgery	❑ Cefazolin	❑ Vancomycin
Orthopedic Surgery		
Orthopedic	❑ Cefazolin	❑ Clindamycin
-Neuromuscular scoliosis repair and/or spinal procedure involving a patient with neuromuscular scoliosis -Type III Open Fracture	❑ Cefazolin **PLUS** Gentamicin	❑ Clindamycin **PLUS** Gentamicin
Open Fractures with soil contamination	❑ Ampicillin-sulbactam **PLUS** Gentamicin (Type II and III only)	❑ Clindamycin **PLUS** Gentamicin (Type II and III only)
Urology		
Procedures WITHOUT entry into the urinary tract	❑ Cefazolin	❑ Clindamycin
Procedures WITH entry into the urinary tract Procedures involving implanted prosthesis	❑ Cefazolin **PLUS/MINUS** ❑ Gentamicin	❑ Gentamicin
Procedures involving the bowel or oropharyngeal mucosa	❑ Cefazolin **PLUS** Metronidazole	❑ Gentamicin **PLUS** Metronidazole
Other	❑ Other:	

Physician signature ____ Time ______________ Date ______________

***Requires original signature*