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.

Additional comments:	Surgery case information	on						
Co-case, Pasisting surgeon (circle one)	Surgery/procedure date	Hospital	Hospital Preferred start time					
If co-case, lst operating physician 2nd operating physician	Primary surgeon/ordering MD			Contact	number			
Procedure(s) (as to appear on consent) Procedure length	Co-case/Assisting surgeon (cire	cle one)						
Procedure length	If co-case, 1st operating physici	o-case, 1st operating physician 2nd operating physician						
Equipment needed PreOp diagnosis(es) 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? Proor Proor Proor Patient demographics Primary language if other than English Medical record # Legal name (last) (first) (MI) Street address City State Zip Date of birth Image I female Social Security# (c) Ht: Wt: kg Allergies and reactions: Alternative contact person name (c) (wt) (ext) (c) Authorization to leave messages on patient answering system? Y IN Insurance Information Primary insurance carrier Insurance identification # Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (please specify) Lab draw location: Proor CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Date of birding Dictated Faxed Date of birding Dictated Faxed Discian Orders/Medication/DVT Orders Lab/EKG/Rad ordered (please specify) Lab draw location: Proor CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Date of birding Dictated Faxed Date of print Disciant order of please of place or place	Procedure(s) (as to appear on co	onsent)						
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: OutP1 OutP1/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 Medical record # Legal name (last) (first) (MI) Street address City State Zip Date of birth Phone (H) (W) (ext.) (C) Ht Wt kg Allergies and reactions: Authorization to leave messages on patient answering system? Y N Insurance Information (w) (ext.) (C) Authorization # Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Eff	Procedure length	(give only your estimated time)	CPT 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/reserveroom TBA InPt (Room #) PreOp visit required? Y N 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 Imale I female Social Security# - Phone (H) (W) (cext.) (C) Ht: Wt: kg Allergies and reactions: Alternative contact person name Relationship to patient Insurance Information Primary insurance carrier Insurance identification # Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Phinary Insurance identification # Referral/Auth/Precert # Imsurance 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 IMD to Bring Inicated Image Day of Surgery Other Image Imag	Equipment needed							
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/INC for	PreOp diagnosis(es)			ICD-10 c	ode(s)			
<pre>(i.e. implants, risks, implained 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 fordays (reservation made by MD office) Admit after surgery fordays Patient demographics Primary language if other than English</pre>	Anesthesia: 🗖 Gen 🛛 Loca	al 🛛 Anes Choice 🖓 Ma	ac 🛛 Other	None				
Service status: OutPt OutPt OutPt/reserve room TBA InPt (Room #) PreOp visit required? Y N Admit after surgery to PICU/NICU/IMC for	Additional comments:		d mobility, commer	nts. etc.) If im r	plants are nee	ded, please be sp	ecific.	
Admit after surgery to PICU/NICU/IMC fordays (reservation made by MD office) Admit after surgery fordays Patient demographics Primary language if other than English	Service status: OutPt O							
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 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/EKG/Rad ordered (please specify) Lab draw location: Pre-op Intra-op CPL (done) Apply SCD's H&P MD to Bring Dictated Day of Surgery Other								
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 Lab draw location: Pre-op CPL (done) Apply SCD's H&P Other (• •	Fnølish						
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 Other ((MI)	
Date of birth male female Social Security# - Phone (H) (W) (ext.) (C) Ht: Wt: kg Allergies and reactions: Relationship to patient Alternative contact person name Relationship to patient		-						
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 Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (<i>please specify</i>) Lab draw location: Pre-op Intra-op CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Day of Surgery Other (
Alternative contact person name Relationship to patient Contact phone (H) (W) (ext.) (C) Authorization to leave messages on patient answering system? Y N N Insurance Information Primary insurance carrier Referral/Auth/Precert # Effective date Secondary 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 (<i>please specify</i>) Lab draw location: Pre-op Intra-op CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Day of Surgery Other (
Contact phone (H) (W) (ext.) (C) Authorization to leave messages on patient answering system? Y IN Insurance Information Primary insurance carrier Insurance identification # Referral/Auth/Precert # Insurance identification # Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (<i>please specify</i>) Lab draw location: I Pre-op I Intra-op I CPL (done) Apply SCD's H&P I MD to Bring I Dictated I Faxed I Day of Surgery I Other (mg/kg) mg dose Office scheduler	Ht: Wt: kg Al	lergies and reactions:						
Authorization to leave messages on patient answering system? Q Q N Insurance Information Primary insurance carrier Insurance identification # Referral/Auth/Precert # Insurance identification # Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab /EKG/Rad ordered (<i>please specify</i>) Lab draw location: Q Pre-op Q Intra-op Q CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Day of Surgery Q Other (mg/kg)mg dose Office scheduler	Alternative contact person nam	ne	Rela	tionship to pat	ient			
Insurance Information Primary insurance carrier Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # 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	Contact phone (H)	(W)	(ext	.)	(C)			
Primary insurance carrier Insurance identification # Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Insurance identification # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (<i>please specify</i>) 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	Authorization to leave message	es on patient answering system?	IY IN					
Referral/Auth/Precert # Effective date Secondary insurance carrier Insurance identification # Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (<i>please specify</i>) 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	Insurance Information							
Secondary insurance carrier Insurance identification #	Primary insurance carrier	Primary insurance carrier Insura			rance identification #			
Referral/Auth/Precert # Physician Orders/Medication/DVT Orders Lab/EKG/Rad ordered (<i>please specify</i>) 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	Referral/Auth/Precert #	Effective date						
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) Office scheduler	Secondary insurance carrier		Insurance ide	ntification # $_{-}$				
Lab/EKG/Rad ordered (<i>please specify</i>) 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	Referral/Auth/Precert #							
Lab draw location: Pre-op Intra-op CPL (done) Apply SCD's H&P MD to Bring Dictated Faxed Day of Surgery Other	Physician Orders/Med	ication/DVT Orders						
□ Other (mg/kg) mg dose Office scheduler	Lab/EKG/Rad ordered (please s	specify)						
Office scheduler	Lab draw location: Dere-op	Intra-op CPL (done) A	Apply SCD's H&P	🖵 MD to Bring	g 🖵 Dictated	d 🖸 Faxed 🛄 Da	ay of Surgery	
Office scheduler								
	Office scheduler							
Physician signature Date Date	Physician signature			Time		Date		

**Requires original signature

Patient demographics

Medical Record # ____

____ Legal Name (last)______ (MI) _____

Preop IV antibiotic orders

Deharmacy 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	
Ca	rdiothoracic		
-Cardiac surgery -Non-cardiac thoracic procedures	Cefazolin	Vancomycin	
Ger	neral 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 r	neck/plastic surgery		
Head and neck/plastic surgery	 Cefazolin OR Ampicillin-sulbactam OR Cefazolin PLUS Metronidazole 	Clindamycin Neurosurgery	
Ne	urosurgery		
Neurosurgery	🖵 Cefazolin	Vancomycin	
Ortho	pedic 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 _____ Date _____

**Requires original signature