Please fax results to:
212 - 734 - 0407

PHYSICIAN'S ORDER FORM
FOR PRE-ADMISSION TESTING

Date of Surgery: ____________________
Patient's Name: ____________________
Surgeon's Name: ____________________

TEST RESULT SUBMISSION:

- **No tests required for healthy patients without medical problems.**
- The patient's name, testing date and date of birth must appear on every test document
- All laboratory tests must be performed by a CLIA (Clinical Laboratory Improvement Act) approved laboratory. Lab tests are good for 30 days prior to surgery.
- In the absence of recent medical problems, chest X-ray is valid for six months and ECG is valid for 3 months.

☐ No testing Ordered or Required

ICD 9 Codes
Must indicate reason/diagnosis for all testing
Please refer to the next page for a list of the ICD 9 codes.

Laboratory Tests	INDICATOR	ICD-9 CODES
☐ BMP (BUN, Na, K, Cl, Glu, Creat, Ca, CO2) ☐ CMP (Alb, TBIL, Ca, CO2, Creat, Glu, AlkP, TP, Na, SGOT,BUN,SGPT,Cl,K) ☐ Potassium level	Patient has been diagnosed with renal disease Patient is taking a diuretic drug that can cause hypokalemia or any other drug that can cause electrolyte abnormalities Patient is taking digoxin ESRD patients on dialysis	
☐ CBC		
☐ PT/PTT/NR	Patients whose surgery is likely to be performed under regional anesthesia and are taking or have recently taken anticoagulant drugs	
☐ Urinalysis		
☐ HCG Serum ☐ HCG Urine	If the patient is a woman of childbearing age	
☐ ECG Age is not a factor.	Patient has at least 1 risk factor (Ischemic heart disease, Renal disease, Cerebrovascular disease, Diabetes, Hx. Of heart failure)	
☐ Chest X - Ray Chest Xray is not required if patient's condition is stable	Patients who have chronic pulbmonary disease (emphysema, bronchitis, asthma), chronic congestive heart failure or who have experienced a recent exacerbation of symptoms deviating from a stable state	
☐ Sleep study	Patient with diagnosis of or symptoms suggestive of obstructive sleep apnea if appropriate for age, unless determined by Otolaryngologist, Neurologist or Pulmonologist	

Date: ____________ Time: ____________

M.D. Signature: ______________________________ UPIN# ____________

PHY-804 (9/09)

SM40

PATIENT NAME: ____________
DOB: ____________
DATE OF SURGERY: ____________

HISTORY & PHYSICAL

Requesting MD: ____________ Planned Procedure: ____________

Chief Complaint ____________
History of Present Illness: ____________
Past Surgical History: ____________

Medical History	NEG	POS	COMMENT IF POSITIVE
Hypertension/Heart	☐	☐	
COPD/Asthma/Sleep Apnea	☐	☐	
Renal Failure/Dialysis	☐	☐	
Bleeding/Blood Disorder	☐	☐	
Periph. Vas. Dis/Claudication	☐	☐	
Communicable Disease (Hepatitis)	☐	☐	
Cancer	☐	☐	
Other	☐	☐	

Medication	Dose	Frequency

Allergies ____________
History of Anesthesia reaction: ☐ Yes ☐ No
Tobacco ______ PPD ______
Alcohol ______ DPD ______
Family/Social Hx: ______
Recreational Drugs: ____________
Herbal Drugs: ____________

REVIEW OF SYSTEM
Neg Positive *(check if positive)*
Constitu. ☐ ☐ Anorexia ☑ Fatigue ☐ Fever ☐ Weight Loss
Cardio ☐ ☐ Angina ☐ DOE ☐ Orthopnea ☐ Edema ☐ Palpitations ☐ Syncope
Resp ☐ ☐ Cough ☐ Dyspnea ☐ Pleuritic chest pain ☐ Other ______
Gastro ☐ ☐ Gerd ☐ Vomiting ☐ Diarrhea ☐ Ulcer ☐ Disphagia
GU ☐ ☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria
Neuro ☐ ☐ Seizure ☐ Migraine ☐ Other
GYN: Last Menstrual Period: ______

REVIEW OF SYSTEMS CONT.
Neg Positive *(check if positive)*
Skin ☐ ☐ Rash ☐ Ulcer ☐ Other ______
Hemo ☐ ☐ Easy bruising ☐ Hemoptysis ☐ Epistaxis ☐ Melena
Endo ☐ ☐ Diabetes ☐ Thyroid Dis ☐ Heat/cold intolerance
Psych ☐ ☐ Depression ☐ Anxiety
M/Skel ☐ ☐ Joint Pain ☐ Back pain ☐ Arthritis
ENT ☐ ☐ Decreased hearing ☐ Decreased Vision ☐ Blind

IS PREGNANCY A POSSIBILITY? ☐ Yes ☐ No ______

Height: ______ Ft ______ In	Weight: ______ Kg	BP:	P:	R:	Pain (0-10):

Physical Exam	WNL	Patient Refused	Explanation of Abnormal Findings
1 General	☐	☐	
2 Skin	☐	☐	
3 HEENT	☐	☐	
4 Neck	☐	☐	
5 Cardio	☐	☐	
6 Chest/Lung	☐	☐	
7 Abd	☐	☐	
8 Extremities	☐	☐	
9 Neuro	☐	☐	
10 Nodes	☐	☐	
11 Breasts Deferred ☐	☐	☐	
12 Rectal/Pelvic Deferred ☐	☐	☐	
13 PAP SMEAR	☐ PERFORMED	☐ DEFERRED	☐ REFUSED

Other Comments

DX
SURGICAL
INDICATION ____________

PLAN /
PROPOSED
TREATMENT ____________

Date: ______ **Examining/Consulting Physician Signature:** ______
If not performed by MEETH credentialed physician: I attest that the above history & physical is current and accurate.
Date: ______ **Admitting Surgeon Signature:** ______

AMBULATORY SURGERY HISTORY & PHYSICAL MUST BE PERFORMED NO EARLIER THAN THIRTY (30) DAYS PRIOR TO SURGERY
INPATIENT/SDA HISTORY & PHYSICAL MUST BE PERFORMED NO EARLIER THAN SEVEN (7) DAYS PRIOR TO SURGERY

Update: If the date of the History & Physical is earlier than seven (7) days before the date of surgery, complete the following section.
☐ Patient checked today & there is no change in the History & Physical
☐ History & Physical has changed (Please see attached): ______
Date: ______ **Physician Signature:** ______

Fax to: **at**

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