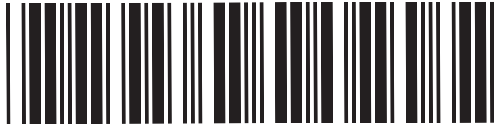
MERIDIAN HEALTH • RMC

PRE ADMISSION/TESTING ORDERS

81206-002RX (5-11)S



PO0025

Patient Name:______________________________

Date of Birth: ______________________________

Home Phone #: ____________________________

PAT Date: ________________________________

Please report to the Pre-Admission Testing Area on:

______________	______________	______________	______________________________
Day	Date	Time	Procedure

____________	______________________________	______________________________
Date of Surgery	Surgeon	Procedure

☐ Patient advised of Total Joint Class on day of PAT. **BRING THIS FORM WITH YOU**

ALLERGIES: ____

Send results to ____for medical clearance.

PREADMISSION TESTING ORDERS

Please check appropriate studies. Must include clinical reason for exam.

☐ Basic Metabolic Panel ICD9 Code:__________

☐ Comprehensive Metabolic Panel ICD9 Code:__________

☐ H&H ICD9 Code:__________

☐ CBC with Automated diff ICD9 Code:__________

☐ INR/PTT ICD9 Code:__________

☐ Urinalysis ICD9 Code:__________

☐ Urine Pregnancy Test (UCG) ICD9 Code:__________

☐ MRSA Nasal Scr ICD9 Code: ____________

☐ Chest X-Ray ICD9 Code: ____________

☐ EKG ICD9 Code: ____________

Additional Orders:

____ICD9 Code:__________

____ICD9 Code:__________

____ICD9 Code:__________

☐ **PRE OP ANTIBIOTIC ORDERS:** ☐ **NO** ☐ **YES:**______________________________________

____

PREADMISSION BLOOD BANK ORDERS

☐ Type & Screen Autologous_________units

Note: If antibodies are detected, the ordering physician will be notified to discuss potentially cross matching units.

GENERAL INSTRUCTIONS

- If your physician has ordered a Comprehensive Metabolic Panel, please do not eat or drink anything after midnight the night before your appointment.
- Please bring a urine specimen in a clean container if urinalysis is ordered.
- Please list medications, dosages, and times on a separate piece of paper.

If you are using lab tests from a physician's office or outside testing facility, please bring copies of your test results. Test results may be faxed to Surgical Day Stay Unit at 732-224-7497. All test results must be at the Surgical Day Stay Unit 24 hours prior to your surgery.

If test results are to be faxed to a physician, please bring the fax number and phone numbers with you.

Physician Signature: ________________________________ Date:____________ Time:________AM/PM