North Shore LIJ Huntington Hospital
North Shore-Long Island Jewish Health System

PRE-SURGICAL TESTING ORDER FORM

OR Fax: (631) 351-2696 ASU Fax: (631) 351-2763 Admitting Fax (631) 351-2652 PST Fax: (631) 760-2129

Patient's Name: ____________________ ____________________ ______________________
(Last) *(First)* *(Previous last name)*

Date of Birth: ____________________ Home phone: ________________ Cell phone: ________________

DATE of ADMISSION: ______________________ €ASU €AM Admit € PASU

HISTORY & PHYSICAL ☐ By Surgeon
☐ By NP in PST

☐ Consulting Physician(s):______________________ ________________ ________________
(first and last name) *(fax number)* *(telephone number)*

______________________ ________________ ________________
(first and last name) *(fax number)* *(telephone number)*

Above information requested/confirmed by:________________, Admitting Representative

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LABORATORY *PST testing can all be performed **non-fasting** .

****Patients on anticoagulation therapy will only have coagulation tests the morning of surgery.**

☐ Urine Pregnancy Test ICD9___________
(Required for all females of child bearing age)
☐ CBC with Differential ICD9 ___________
☐ Basic Metabolic Panel ICD9 ___________
☐ U/A ICD9 ___________
☐ PT/INR ICD9 ___________
☐ APTT ICD9 ___________
☐ OTHER ICD9 ___________
☐ MRSA Nares Screening (For All Total Joint Replacement & Spine Cases) ICD9 _______________

BLOOD BANK

☐ Type, screen only. ICD9 ___________
☐ Type, screen, x-match: Number of Units _____________ ICD9 ___________
Has patient been transfused, received any blood product or pregnant in last 3 months? ☐ NO ☐ YES
If yes, explain: ____

ELECTROCARDIOGRAPHY
☐ E.K.G. ICD9 ___________

RESPIRATORY CARE:
☐ Arterial Blood Gas ICD9 ________
☐ 0_2 Sat ICD9 ________

RADIOLOGY (Note: Any other radiology procedure must be scheduled directly with the department at 351-2297).

☐ Chest, PA and Lat ICD9_________ ☐ Extremity, please specify _____________ ICD9__________

☐ Other: ____________________________________ ICD9 ______________________

PHARMACY *Weight:* ________*lbs* __________ *kg* Allergies:____________________________________

☐ Ancef __________ IVPB in OR prior to incision
☐ Clindamycin _____________ IVPB in OR prior to incision
☐ Vancomycin _____________ IVPB – infusion to be completed within 2 hours of surgical incision
☐ Intravenous Solution: 0.9% Normal Saline@ a rate of: 75 ml/hr **or** ___________________ @ ________

Other Med Orders:____

☐ ANTICOAGULATION MANAGEMENT CONSULT for pre-op teaching (Total Joint Replacement Only)

Operative Consent should read:

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Physician / NP Signature: ____ **Date:** ______________

1PO

1PO

PATIENT PRE-SURGICAL TESTING INSTRUCTIONS

1. The Pre-Surgical Testing order form (on reverse side) is to be completed in the Surgeon's Office, **signed by the Surgeon** and given to the patient who will bring it to the Hospital when he/she comes for their pre-surgical testing.

2. The Pre-Surgical Information form (green form) is a two-part carbonized form. The patient should complete this form at home, as soon as possible, and mail the top copy to Huntington Hospital Admitting Office in the enclosed pre-addressed envelope. The remaining copies should be brought **WITH THIS FORM** to Huntington Hospital when the patient comes for his/her pre-surgical testing appointment. Please remember to sign Authorizations on reverse side of **ALL** green forms. The reverse side is **not** carbonized.

3. Regular hours for pre-admission testing are: Monday, Tuesday, Wednesday and Friday from 7:00 am to 2:15 pm and Thursdays from 7 am to 4 pm. The testing can be done up to 30 days prior to surgery depending upon your Insurance Company's policy. Please contact your Insurance Company for their policy on Pre-Surgical Testing.

4. Your surgeon's office will schedule your surgery date and PST appointment and will confirm these dates with you.

5. On the evening prior to surgery you will be contacted by the Ambulatory Surgery staff to confirm your time of arrival for the following day. Should you not hear from the Hospital by 8 pm the evening before your surgery please call (631) 351-2243 to confirm your arrival time. For those patients scheduled for surgery on Monday, you will receive a telephone call on Friday.

6. Check with your physician if he/she has ordered lab testing that may require you to be without food or drink after midnight. For the majority of testing you do not have to be fasting.

INSTRUCTIONS FOR DAY OF TESTING

1. Complimentary VALET parking is available for your convenience and is located at the Main Entrance off of Park Avenue.

2. Proceed to the Admitting Office, located on the ground floor level, for registration. Once registered, you will be called into the PST unit for your testing. Please allow 1-1/12 hours for your visit.

3. You must bring a list of your medications and dosages, the name, telephone and fax numbers of your medical consulting physicians(s) (not your surgeon) with you to your PST appointment.

4. **PLEASE BRING IN YOUR INSURANCE IDENTIFICATION CARDS AT TIME OF PRE-SURGICAL TESTING.**

5. Should you need to make any changes to your PST appointment, please call (631) 351-2598.