MANDATORY FIELDS IN CAPITAL LETTERS

Facility Use Only

Hospital Chart #	**Waitlist Start Date**	**Booking ID #**

SECTION 1: SURGICAL BOOKING INFORMATION

PREFERRED FACILITY:	Date/Time of Surgery:	**POST-OP BED REQUIRED**	**ADMISSION TYPE**	
Date/Time of Admission:		☐ Critical Care ☐ Surgical Telemetry ☐ Observation ☐ Other:	☐ DS ☐ DAS/SDS ☐ IP __ days before surgery ☐ Other:	**Saskatoon-PAC Admission** ☐ DS_PAC ☐ PSDS

PATIENT LAST NAME	**FIRST NAME**	Middle Name	Billing information (if not SK gov):

HEALTH SERVICE NUMBER	**DATE OF BIRTH** (MM/DD/YYYY)	**SEX** ☐ M ☐ F ☐ X Preferred Pronoun:	Alternate Contact Name:

PERMANENT ADDRESS	**CITY OR TOWN**	**PROVINCE**	**POSTAL CODE**	Alternate Contact Phone #:

PRIMARY PHONE #	Cell Phone #	Work/Other Phone #	Email:

REFERRING PHYSICIAN	**DATE REFERRAL RECEIVED** (MM/DD/YYYY)	**FIRST CONSULT DATE** (MM/DD/YYYY)	Family Physician

DIAGNOSIS CODE	**DIAGNOSIS DESCRIPTION** (If using OTHER, a free text description must be entered)	**PROVEN OR SUSPECTED CANCER** ☐ Yes ☐ No

Pre-op diagnosis:

SURGEON	**PROCEDURE**	**LATERALITY:**	**SITE:**
1			
2			
3			
Assistant Required: ☐ Yes ☐ No	Assistant Name:	**EST. PROCEDURE TIME**:	

TIME UNAVAILABLE DATES WERE DISCUSSED WITH PATIENT ☐ Yes ☐ No	Unavailable from:	Unavailable to:	Reason:	**AVAILABLE SHORT NOTICE (1-5 DAYS)** ☐ Yes ☐ No

Preferred anesthetic: ☐ General ☐ Spinal/Epidural ☐ Retrobulbar ☐ Local ☐ Topical ☐ MAC ☐ Regional ☐ None

Alerts/Additional Conditions: ☐ None

☐ Advance Directive ☐ ARO (_____) ☐ BMI over 40

☐ Malignant hyperthermia ☐ Diabetes Type 1 ☐ Diabetes Type 2 ___IDDM ___ NIDDM

☐ Previous complications:

☐ Other:

Allergies: ☐ None known

☐ Latex Allergy

☐ Metal Allergy

☐ Other:

Operating Room Needs: ☐ Bariatric Equipment ☐ C-arm (Fluoro)

☐ Items/Equipment/Loaner sets:

Booking Comments:

SURGEON SIGNATURE

***** For All Pre-Op Physician Orders, including labs, imaging and consults, refer to page 2 *****

SECTION 2: PHYSICIAN ORDERS – SASKATOON, SK

PATIENT LAST NAME	FIRST NAME	HEALTH SERVICE NUMBER

CONSULTS:

☐ None required
☐ Internal Medicine (must specify reason):

☐ Anesthesia (must specify reason):

☐ Physical Therapy
☐ Occupational Therapy
☐ Bleeding Disorder Program
☐ Ostomy

PREADMISSION CLINIC (PAC): (Include all relevant reports with chart [e.g. cardiology, respiratory, neurology, etc.])

☐ None required
☐ Reason for PAC:

Other
☐ In Person PAC
☐ Virtual PAC/ Virtual Candidate
(Appropriateness for virtual consultation will be assessed by PAC)

MEDICAL IMAGING:

☐ None required
☐ X-ray and Type

☐ MRI
☐ CT Scan
☐ Pre-admission Chest X-ray
☐ Intraoperative Imaging Required

LABORATORY: (Results, excluding Group & Screen, are valid for 90 days unless specified otherwise)

☐ None Required
☐ Surgery GRID Algorithm
☐ CBC
☐ PT/PTT/INR
☐ Electrolytes
☐ Glucose
☐ Urea/Creatinine
☐ Albumin
☐ ABG
☐ HGB A1C
☐ Group & Screen
☐ Cross Match __Units
☐ Autologous ____ Units

Anemia Studies
☐Ferritin
☐Fe/TIBC/TSAT
☐B12
☐ ECG
☐ LFT
☐ PFT
☐ Quick/Frozen Section
☐ Urine C & S
☐ Urinalysis

Day of Surgery:
Pregnancy Test
☐ Serum ☐ Urine

☐ Reorder lab work if > 90 days

☐ Other:

MEDICATIONS INSTRUCTIONS:

☐ Bowel Prep:
☐ Antibiotics
☐ Medications to Stop
☐ Other

ERAS / PATHWAYS:

☐ Colorectal ERAS	☐ Gyne / Oncology	☐ Radical Prostatectomy
☐ Cardiac ERAS	☐ Hip and Knee	☐ Radical Cystectomy
		☐ Other

PRE-PRINTED / PRE-OPERATIVE ORDERS REQUIRED ☐ Yes ☐ No

OTHER INSTRUCTIONS / ORDERS (SPECIFY)

SURGEON SIGNATURE:	DATE/TIME