

Site		Health Record #		Encounter #	
Date Submitted (yyyy-Mon-dd)		Date Admitting Received (yyyy-Mon-dd)		Admitting Surgeon	
Last Name		First Name		Middle	Age
Date of Birth (yyyy-Mon-dd)	<input type="checkbox"/> Female <input type="checkbox"/> Male	PHN/Unique Lifetime Identifier	Federal Gov't/Out of Province #/Self-pay/Uninsured <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address (Apt/Street No.)			City	Province	
Postal Code	Home Phone	Cell Phone	Business Phone (ext.)		
Parent(s)/Legal Guardian Name		Phone	Family Physician	WCB Claim #	
Does patient have cancer related to this surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected		Are there any dates the patient is unavailable? <input type="checkbox"/> No <input type="checkbox"/> Yes, from _____ to _____			
Surgery Date (yyyy-Mon-dd)	Decision to Treat Date (yyyy-Mon-dd)	Ready to Treat Date (yyyy-Mon-dd)	Referral Date to Surgeon (yyyy-Mon-dd)		
PAC <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-op Assessment Clinic Date (yyyy-Mon-dd)	Pre-Op Assessment Referral <input type="checkbox"/> ICU <input type="checkbox"/> Internist <input type="checkbox"/> Anaesthesiologist		Referring Physician Name	
Admit Category Within		<input type="checkbox"/> 3 days <input type="checkbox"/> 6 weeks	<input type="checkbox"/> 1 week <input type="checkbox"/> 12 weeks	<input type="checkbox"/> 2 weeks <input type="checkbox"/> 16 weeks	<input type="checkbox"/> 3 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> 4 weeks
Admit Type (select one)		<input type="checkbox"/> Admit _____ days Pre-Op	<input type="checkbox"/> Day Surgery	<input type="checkbox"/> 24 Hour Stay	
<input type="checkbox"/> Urgent		<input type="checkbox"/> Admit Day of Procedure	<input type="checkbox"/> Medical	<input type="checkbox"/> ICU Post-Op	
<input type="checkbox"/> Elective		<input type="checkbox"/> Step down/Intermediate Care Unit	<input type="checkbox"/> Observation Post-Op	<input type="checkbox"/> Admit _____ days post-op	
Provisional Diagnosis				pCATS/aCATS Diagnosis Code	
Procedure 1 Code	Description	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral		Skin to Skin Time	
		Surgeon		Insured Procedure <input type="checkbox"/> No	
Procedure 2 Code	Description	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral		Skin to Skin Time	
		Surgeon		Insured Procedure <input type="checkbox"/> No	
Special O.R. Equipment/Prosthesis			Assistant required <input type="checkbox"/> Yes <input type="checkbox"/> No	Fluoroscopy/C-arm <input type="checkbox"/> Yes <input type="checkbox"/> No	
Required Anaesthetic					
<input type="checkbox"/> General		<input type="checkbox"/> Regional (spinal, epidural, peripheral)		<input type="checkbox"/> Procedural Sedation/Analgesia (without anaesthesia support)	
<input type="checkbox"/> Local		<input type="checkbox"/> IV Regional (Bier)		<input type="checkbox"/> Monitored Anaesthetic Care (with anaesthesia support)	
Special Medical Concerns/Needs/Allergies					
<input type="checkbox"/> Autologous Blood		<input type="checkbox"/> Creutzfeldt-Jakob Disease precautions		<input type="checkbox"/> Type 1 Diabetes	
<input type="checkbox"/> Antibiotic Resistant Organisms		<input type="checkbox"/> Latex Allergy		<input type="checkbox"/> BMI _____	
		<input type="checkbox"/> Malignant Hyperthermia		<input type="checkbox"/> Type 2 Diabetes	
				<input type="checkbox"/> Obstructive Sleep Apnea	
Name			Signature	Date (yyyy-Mon-dd)	
Attachments					
<input type="checkbox"/> Prosthesis		<input type="checkbox"/> Hip <input type="checkbox"/> Knee		<input type="checkbox"/> Spine <input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> History		<input type="checkbox"/> Orders <input type="checkbox"/> Consult		<input type="checkbox"/> Legal Guardian Consent	
<input type="checkbox"/> Creutzfeldt-Jakob Disease Risk Assessment Tool		<input type="checkbox"/> Self/Care-Giver Assessment		<input type="checkbox"/> Consent	
				<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Lab					
<input type="checkbox"/> ECG					
Postponement	Reason for Postponement	Rescheduled Surgery Date (yyyy-Mon-dd)	Rescheduled Admission Date (yyyy-Mon-dd)	Initials	