

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"/> 1 week <input type="checkbox"/> 2 weeks <input type="checkbox"/> 3 weeks <input type="checkbox"/> 4 weeks <input type="checkbox"/> 6 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 26 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"/> Type 2 Diabetes <input type="checkbox"/> Antibiotic Resistant Organisms <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> BMI _____ <input type="checkbox"/> Obstructive Sleep Apnea					
Name		Signature		Date (yyyy-Mon-dd)	
Attachments Prosthesis <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Spine <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Lab <input type="checkbox"/> History <input type="checkbox"/> Orders <input type="checkbox"/> Consult <input type="checkbox"/> Legal Guardian Consent <input type="checkbox"/> Consent <input type="checkbox"/> ECG <input type="checkbox"/> Creutzfeldt-Jakob Disease Risk Assessment Tool <input type="checkbox"/> Self/Care-Giver Assessment <input type="checkbox"/> Other (specify) _____					
Postponement	Reason for Postponement	Rescheduled Surgery Date (yyyy-Mon-dd)	Rescheduled Admission Date (yyyy-Mon-dd)	Initials	