Alberta Health Services

Surgical Booking Request

Place Label Here

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)* ☐ Female ☐ Male	PHN / Unique Lifetime Identifier	Federal Gov't / Out of Province #/Self-pay / Uninsured ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ Suspected	Are there any dates the patient is unavailable? ☐ No ☐ 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 ☐ Yes ☐ No	Pre-op Assessment Clinic Date *(yyyy-Mon-dd)*	**Pre-Op Assessment Referral** ☐ ICU ☐ Internist ☐ Anaesthesiologist	Referring Physician Name

Admit Category Within ☐ 3 days ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ 6 weeks ☐ 12 weeks ☐ 16 weeks ☐ 26 weeks

Admit Type *(select one)* ☐ Urgent ☐ Elective	☐ Admit _____ days Pre-Op ☐ Admit Day of Procedure ☐ Step down / Intermediate Care Unit	☐ Day Surgery ☐ Medical ☐ Observation Post-Op	☐ 24 Hour Stay ☐ ICU Post-Op ☐ Admit _____ days post-op

Provisional Diagnosis	pCATS / aCATS Diagnosis Code

Procedure 1 Code	Description	☐ Right ☐ Left ☐ Bilateral	Skin to Skin Time
		Surgeon	Insured Procedure ☐ No
Procedure 2 Code	Description	☐ Right ☐ Left ☐ Bilateral	Skin to Skin Time
		Surgeon	Insured Procedure ☐ No

Special O.R. Equipment/Prosthesis	Assistant required ☐ Yes ☐ No	Fluoroscopy / C-arm ☐ Yes ☐ No

Required Anaesthetic
☐ General ☐ Regional *(spinal, epidural, peripheral)* ☐ Procedural Sedation/Analgesia *(without anaesthesia support)*
☐ Local ☐ IV Regional *(Bier)* ☐ Monitored Anaesthetic Care *(with anaesthesia support)*

Special Medical Concerns / Needs / Allergies

☐ Autologous Blood ☐ Creutzfeldt-Jakob Disease precautions ☐ Type 1 Diabetes ☐ Type 2 Diabetes
☐ Antibiotic Resistant Organisms ☐ Latex Allergy ☐ Malignant Hyperthermia ☐ BMI _____ ☐ Obstructive Sleep Apnea

Name	Signature	Date *(yyyy-Mon-dd)*

Attachments Prosthesis ☐ Hip ☐ Knee ☐ Spine ☐ Other *(specify)* _____ ☐ Lab
☐ History ☐ Orders ☐ Consult ☐ Legal Guardian Consent ☐ Consent ☐ ECG
☐ Creutzfeldt-Jakob Disease Risk Assessment Tool ☐ Self / Care-Giver Assessment ☐ Other *(specify)* _____

Postponement	**Reason for Postponement**	**Rescheduled Surgery Date** *(yyyy-Mon-dd)*	**Rescheduled Admission Date** *(yyyy-Mon-dd)*	**Initials**