

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)
<b>PAC</b> Yes      No	Pre-op Assessment Clinic Date (yyyy-Mon-dd)		<b>Pre-Op Assessment Referral</b> ICU      Internist      Anaesthesiologist		Referring Physician Name
<b>Admit Category Within</b>		3 days 6 weeks	1 week 12 weeks	2 weeks 16 weeks	3 weeks 26 weeks      4 weeks
<b>Admit Type (select one)</b> 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	
Procedure 2 Code	Description			Right      Left      Bilateral	Skin to Skin Time
				Surgeon	
Special O.R. Equipment/Prosthesis				Assistant required Yes      No	Fluoroscopy/C-arm Yes      No
<b>Required Anaesthetic</b>					
General Local		Regional (spinal, epidural, peripheral) IV Regional (Bier)		Procedural Sedation/Analgesia (without anaesthesia support) Monitored Anaesthetic Care (with anaesthesia support)	
Special Medical Concerns/Needs/Allergies					
Autologous Blood Antibiotic Resistant Organisms		Creutzfeldt-Jakob Disease precautions Latex Allergy		Type 1 Diabetes BMI _____	Type 2 Diabetes Obstructive Sleep Apnea
Name			Signature		Date (yyyy-Mon-dd)
<b>Attachments</b>		Prosthesis History      Orders	Hip Consult	Knee	Spine Legal Guardian Consent Self/Care-Giver Assessment
		Creutzfeldt-Jakob Disease Risk Assessment Tool		Other (specify) _____ Consent Other (specify) _____	
<b>Postponement</b>	<b>Reason for Postponement</b>			<b>Rescheduled Surgery Date (yyyy-Mon-dd)</b>	<b>Rescheduled Admission Date (yyyy-Mon-dd)</b>