LenoxHill Hospital

☒ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to **866-219-5545**
☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to **866-231-1027**

PHYSICIAN'S ORDER FORM FOR PRE-ADMISSION TESTING

Date of Surgery:
Patient's Name:
Surgeon's Name: **Benjamin B. Bedford, M.D.**

Please fax results to:

Jasmin Laboy
914-725-6972

TEST RESULT SUBMISSION:

- **No tests required for healthy patients without medical problems.**
- The patient's name, testing date and date of birth must appear on every test document
- All laboratory tests must be performed by a CLIA (Clinical Laboratory Improvement Act) approved laboratory. Lab tests are good for 30 days prior to surgery.
- In the absence of recent medical problems, chest X-ray is valid for six months and ECG is valid for 3 months.

History & Physical will be performed by:

☐ Surgeon ☐ Raisler Testing Center Physician (LHH)

☐ Other MD: Name _____ MD Telephone _____

☐ No testing Ordered or Required

ICD 9 Codes
Must indicate reason/diagnosis for all testing
Please refer to the next page for a list of the ICD 9 codes.

Laboratory Tests	INDICATOR	ICD-9 CODES
☐ BMP (BUN, Na, K, Cl, Glu, Creat, Ca, CO2) ☒ CMP (Alb, TBIL, Ca, CO2, Creat, Glu, AlkP, TP, Na, SGOT,BUN,SGPT,Cl,K) ☐ Potassium level	Patient has been diagnosed with renal disease Patient is taking a diuretic drug that can cause hypokalemia or any other drug that can cause electrolyte abnormalities Patient is taking digoxin ESRD patients on dialysis	
☒ CBC		
☒ PT/PTT/NR	Patients whose surgery is likely to be performed under regional anesthesia and are taking or have recently taken anticoagulant drugs	
☒ Urinalysis		
☐ HCG Serum ☐ HCG Urine	If the patient is a woman of childbearing age	
☒ ECG Age is not a factor.	Patient has at least 1 risk factor (Ischemic heart disease, Rena disease, Cerebrovascular disease, Diabetes, Hx. Of heart failure)	
☒ Chest X - Ray	Patients who have chronic pulbmonary disease (emphysema, bronchitis, asthma), chronic congestive heart failure or who have experienced a recent exacerbation of symptoms deviating from a stable state	
☐ Sleep study	Patient with diagnosis of or symptoms suggestive of obstructive sleep apnea if appropriate for age, unless determined by Otolaryngologist, Neurologist or Pulmonologist	
☐		

Date: _____ Time: _____

M.D. Signature: _____ UPIN# _____

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FORM D

PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

Please fax results to:

Jasmin Laboy

914-725-6972

DATE OF SURGERY: _____ PATIENT NAME: _____ _____ D.O.B _____

PLANNED PROCEDURE: _____

History of Present Illness

Past Medical History	Yes	No		Yes	No		Yes	No		Yes	No
Hypertension	☐	☐	Angina	☐	☐	Liver Disease	☐	☐	Blood Clots	☐	☐
Diabetes	☐	☐	Stroke/TIA	☐	☐	Thyroid disease	☐	☐	Bleeding problems	☐	☐
Myocardial Infarction	☐	☐	Lung disease	☐	☐	Kidney Disease	☐	☐	Blood transfusions	☐	☐

Other/Explanation for Positive History: _____

Past Surgical History

Advanced Directive ☐ Yes ☐ No _____ Health Care Proxy ☐ Yes ☐ No _____

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS.

Medication Name	Dose (mg, mcg)	Route (PO,GT,SC,IV)	Frequency

*If more space is required continue on progress note

Review of Systems	Neg	Positive (Check if positive)
Constitutional	☐	☐ Anorexia ☐ Fatigue ☐ Fever ☐ Weight loss
Cardiovascular	☐	☐ Angina ☐ DOE ☐ Orthopnea ☐ Edema ☐ Palpitations ☐ Syncope
Respiratory	☐	☐ Cough ☐ Dyspnea ☐ Pleuritic chest pain ☐ Other _____
Gastrointestinal	☐	☐ Stomatitis ☐ Nausea ☐ Vomitting ☐ Diarrhea ☐ Constipation ☐ Dysphagia
Genitourinary	☐	☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria ☐ Impotence
Neurologic	☐	☐ Paresthesia ☐ Dysesthesia ☐ Headache ☐ Seizure
Skir	☐	☐ Rash ☐ Ulcers ☐ Other _____
Hemorrhage	☐	☐ Easy bruising ☐ Epistaxis ☐ Hemoptysis ☐ Hematochezia ☐ Melena
Endocrine	☐	☐ Polyuria ☐ Polydipsia ☐ Heat/Cold Intolerance
Psychiatric	☐	☐ Depression ☐ Hallucinations ☐ Sexual dysfunction
Musculoskeletal	☐	☐ Joint pain ☐ Back pain
Eyes/Ears	☐	☐ Decreased hearing ☐ Decreased vision
☐ Other		

Allergies _____

History of anesthesia reaction ☐ Y ☐ N

Family History _____

Social History
Tobacco _____
Alcohol _____
Drugs _____
Other _____

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FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

Please fax results to:

Jasmin Laboy

914-725-6972

Patient Name: _____ DOB: _____ MR #: _____ Acct #: _____

OB/GYN History (Not Applicable☐) :

Age of menarche _____ Date of LMP _____ Age of menopause _____ Gravida _____ Para _____

Miscarriage(s) _____ Abortion(s) _____ Age at First Pregnancy _____ Age at Last Pregnancy _____

Use of Oral Contraceptives: ☐ Yes ☐ No Age began oral contraceptives _____ Duration _____

Mammogram ☐ Yes ☐ No _____ PAP Smear ☐ Yes ☐ No _____

PHYSICAL EXAMINATION

Height:	Weight:	BP:	P:	T:	R:	Pain (0-10):	BMI:

	NL	ABNL	Explanation
General	☐	☐	
Skin	☐	☐	
Neck	☐	☐	
HEENT	☐	☐	
Cardic	☐	☐	
Chest/Lung	☐	☐	
Abdominal	☐	☐	
Ext	☐	☐	
Neurologic	☐	☐	
Nodes	☐	☐	
Breasts	☐	☐	
Deferred ☐	☐	☐	
Rectal/Genital/Pelvic	☐	☐	
Deferred ☐	☐	☐	
Other (Specify)			

Significant Labs/X-rays/Exam Diagram

Labs	NL	ABNL
CBC	☐	☐
CHEM	☐	☐
PT/PTT	☐	☐
UA	☐	☐
Other	☐	☐
CXR	☐	☐
EKG	☐	☐
Other	☐	☐

(ie. Stress test, Labs, Endoscopy Etc.)

Pacemaker	☐	☐
Defibrillator	☐	☐

DIAGNOSIS

Examining Provider _____ Lic # _____ Address _____ Phone _____ Fax _____

MD Stamp

MD Signature: _____ Date: _____

SURGEON ASSESSMENT/PLANNED PROCEDURE

FOR AMBULATORY/SDA SURGICAL/INVASIVE PROCEDURES (to be completed day of procedure):
The patient has been examined and the History and Physical has been reviewed. There are no significant changes in the patient's condition unless noted below.

Signature:MD/DO (NP, House Physician, or Resident for podiatry or dental cases)

Print Name: _____ MD/DO/NP Time/Date:

For Podiatry and Dental patients only: I have reviewed the H&P including the update.

Signature: _____ MD/DO/NP Time/Date: _____