Bryn Mawr Hospital
Lankenau Medical Center
Paoli Hospital
Riddle Hospital

Main Line Health®
Well ahead.®

☐ BMH ☐ LMC ☐ PH ☐ RH
☐ CCL ☐ IVR ☐ OR ☐ ENDO

RESET

Reservation / Procedure Order

Case # _____

Patient ID

OUTPATIENT ☐ SPU ☐ MSPU ☐ Surgicenter (LMC) ☐ **Faxed/Phoned to O.R. Scheduling**
Extended Recovery Bed Needed? (23 Hours or Less Admission) ☐ Yes or ☐ NO
INPATIENT ☐ Estimated stay greater than 2 midnights and Inpatient level of care ☐ Faxed/Delivered to Admissions/Registration
Anticipated Length of Stay? (Midnights) ☐ 2 ☐ 3 ☐ 4+ Days

Last Name _____ First _____
DOB _____ Last 4 SS# _____
Home Phone _____
Cell Phone _____
Work Phone _____
E-mail _____
Address _____
City _____ State ____ Zip Code _____
Sex at Birth: ☐ Male ☐ Female Former Patient ☐ Yes ☐ No
Gender: ☐ Male ☐ Female ☐ Trans-man ☐ Trans-woman
Race: ☐ B ☐ W ☐ O (Specify) _____
Height (ft/in): _____ Weight (lbs): _____
EMERGENCY CONTACT _____
RELATIONSHIP _____
HOME PHONE # _____
WORK PHONE # _____
CELL PHONE # _____

Power Of Attorney: _____
HOME PHONE # _____
WORK PHONE # _____
CELL PHONE # _____

Primary Ins. Co: _____
Policy # _____ **Group #** _____
Pre Cert # _____ **Length of Stay** _____
Subscriber Name _____
Relationship _____ DOB _____

Secondary Ins. Co: _____
Policy # _____ **Group #** _____
Pre Cert # _____ **Length of Stay** _____
Subscriber Name _____
Relationship _____ DOB _____
Referral # SPU HMO patients _____

WC/AUTO INS CO _____
Policy # _____ Date of Injury _____
Contact Person _____ Phone # _____

PAT Appointment:
☐ Visit needed ☐ H&P Visit needed ☐ Phone call
☐ **H+P** Performed by _____
Date & Time _____ Phone _____
Physician Signature _____
Date _____ **Time** _____

ADMISSION DATE REQUESTED _____
Attending Physician _____
Diagnosis _____ **ICD Code** _____
Diagnosis _____ **ICD Code** _____
Laterality ☐ NA ☐ Left ☐ Right ☐ Bilateral
Procedure(s) _____
_____
_____
CPT Codes: _____
PROCEDURE DATE _____ Pref'd Time: _____
Assistant: ☐ Yes ☐ No Case Length _____
Cosmetic? ☐ Yes ☐ No Specify portion (time/%) _____
Type of Anesthesia _____
Internal Electronic Device (IED) ☐ Yes ☐ No
If yes, Company/Mfg _____ Device _____
Comments/Request _____
_____
Assistant: ☐ Yes ☐ No Case Length _____
Health Questionnaire Must Accompany Reservation Form
☐ **PAT As per Anesthesia Guidelines**

☐ COVID Testing	☐ ERAS Identified
☐ CBC	☐ SGOT, SGPT, LDH
☐ CBC & Diff	☐ EKG
☐ Comp. Met. (Inc. CO2)	☐ PT/INR
☐ Basic Metabolic	☐ PTT
☐ Electrolytes	☐ Urinalysis
☐ Glucose	☐ Urine C & S (Clean Catch)
☐ BUN	☐ Urine Preg. Test
☐ Creatinine	☐ Serum Preg. Test
☐ Alk-Phosphatase	☐ Chest X-ray

Send patient with Pre-Op Blood Bank Orders to the hospital where the surgery is scheduled within 28 days of surgery
☐ Type & Screen ☐ Prepare Red Cells # ____ units
☐ Prepare Platelets # ____ units ☐ Prepare Plasma # _____ units
☐ Single Donor Platelets # _____ Units
☐ Plasma # _____ Units

☐ HgbA1C
☐ MRSA Nares Culture (minimum 10-14 days pre-op)
☐ Other _____
_____
☐ IV Fluids upon arrival: Start IV 500cc NaCl to run @ KVO rate unless otherwise specified
☐ LATEX ALLERGY
Will also need:
☐ Cardiac Clearance Scheduled with _____
☐ Medical Clearance Scheduled with _____
☐ Dental Clearance Scheduled with _____
☐ Other Scheduled with _____
PCP _____

MLH900-037.1120

PHYSICIAN SIGNATURE REQUIRED TO PROCESS