HCA Florida
Palms West Hospital

Booking Request / Pre-Admit Orders

PHONE NUMBER: 561-784-3128 eFAX NUMBER: 561-273-0120

Patient Name:	**Surgery Date:** **Time:**
Procedure:	
ICD10:	
CPT:	
Surgeon:	

Sex: ☐ M ☐ F DOB: _____ SS#: _____

Address: _____

City: _____ ST _____ Zip _____

Interpreter needed: _____

Insurance 1: _____

Policy 1 #: _____

Insurance 2: _____

Policy 2 #: _____

PCP Name: _____

SPECIAL REQUEST:

☐ Laser ☐ Gamma Probe ☐ Cell Saver ☐ APC
☐ C-Arm ☐ Mini C-Arm ☐ Stealth
☐ Myosure/Aquilex ☐ Novasure
☐ Neuro Monitoring
☐ Implants: _____
☐ Bone/Tissue Graft: _____
☐ Specialty Instruments: _____

Vendor Name: _____

Vendor Number: _____

Email Address: _____

Pt. Phone #1 (mobile): _____

Pt. Phone #2: _____

☐ Inpatient ☐ Outpatient

Expected Level of Anesthesia:
☐ General ☐ MAC ☐ Regional ☐ Local ☐ Block

Pre-Op Date/Time: _____

PRE-ADMIT ORDERS:
Pre-Op eFax #: 561-273-0120
Telephone #: 561-784-3119

☒ Enhanced Surgical Recovery if Appropriate
☒ MRSA/MSSA Screening and Decolonization Protocol
(Required for patients with planned implants)
☒ Initiate Pre-Operative Anesthesia Guidelines
☐ COVID test
☐ Request Hospitalist to Consult/Follow Up Post-Op Admissions

Provider Specific Pre-Admit Orders:
(Anesthesia Guidelines will Order Appropriate Screening Test)

☐ CBC w/auto ☐ CBC w/no diff ☐ UA C&S
☐ Comp Metabolic ☐ Basic Metabolic ☐ Chest X-Ray
☐ PTT ☐ PT/INR
☐ Type & Screen ☐ Type & Cross, # of units _____
☐ EKG: Indication _____
☐ Other: _____

OPTIMIZATION NEEDED:
☐ Medical ☐ Cardiac ☐ Other as Needed: _____

Physician/PA
Signature: _____ **Date:** _____ **Time:** _____

Patient Identification/Label