

ORDERING PHYSICIAN: _____ PHONE: _____ FAX: _____

ADDITIONAL COPIES: 1. **451110 UPMC HAMOT PRE-ADMISSION** 2. _____

PATIENT NAME / PRINT _____ DOB: ____/____/____ SURGICAL DATE: ____/____/____

DEPT.	PROCEDURE / TEST	INDICATION / DIAGNOSIS CODE	DIAGNOSTIC TEST LOCATION / DATE / TIME
<input type="checkbox"/> NO DIAGNOSTIC TESTING REQUIRED			
LAB	HEMATOLOGY 42A <input type="checkbox"/> CBC 45443E <input type="checkbox"/> Hct 7187W <input type="checkbox"/> Hgh <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> ANEMIA <input type="checkbox"/> BLEEDING <input type="checkbox"/> HEM DISORDER <input type="checkbox"/> OTHER: _____	
	COAGULATION 26F <input type="checkbox"/> PT 31732E <input type="checkbox"/> APTT 7773E <input type="checkbox"/> PLATELET	<input type="checkbox"/> LONG-TERM ANTI-COAG USE <input type="checkbox"/> PROSTHETIC VALVE <input type="checkbox"/> VASCULAR DISORDER (DVT) <input type="checkbox"/> CARDIAC DISORDER (A FIB. ETC.) <input type="checkbox"/> NEUROLOGIC DISORDER (TIA) <input type="checkbox"/> OTHER: _____	
	CHEMISTRY 28233E <input type="checkbox"/> K+ 10231A <input type="checkbox"/> CMP 10165F <input type="checkbox"/> BMP <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> DIURETICS <input type="checkbox"/> HIGH-RISK MEDS <input type="checkbox"/> RENAL DISEASE <input type="checkbox"/> OTHER: _____	
	URINE 34F <input type="checkbox"/> UA 6304R <input type="checkbox"/> C & S <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> URINARY FREQ. <input type="checkbox"/> DYSURIA <input type="checkbox"/> OTHER: _____	
	HORMONE <input type="checkbox"/> PREGNANCY TEST 21063E <input type="checkbox"/> URINE 21105R <input type="checkbox"/> SERUM 30163E <input type="checkbox"/> TSH <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> HYPER <input type="checkbox"/> HYPO <input type="checkbox"/> _____	
BLOOD BANK	<input type="checkbox"/> TYPE & SCREEN <input type="checkbox"/> TYPE & CROSS <input type="checkbox"/> AUTOLOGOUS	# UNITS _____ # UNITS _____	
CARDIOPULMONARY	<input type="checkbox"/> EKG <input type="checkbox"/> STRESS TEST <input type="checkbox"/> ECHO <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> CHF <input type="checkbox"/> OTHER: _____	
	RESP <input type="checkbox"/> ABGs <input type="checkbox"/> PULSE OXIMETER <input type="checkbox"/> PFTs <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> COPD <input type="checkbox"/> SOB <input type="checkbox"/> OTHER: _____	
RADIOLOGY	<input type="checkbox"/> CXR <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> COUGH <input type="checkbox"/> ADVENTITIOUS BREATH SOUNDS <input type="checkbox"/> SOB <input type="checkbox"/> WHEEZING <input type="checkbox"/> _____	

DIAGNOSIS: _____ AM
_____/_____/____ PM

PATIENT LABEL

PHYSICIAN'S SIGNATURE _____
DATE _____ TIME _____
**UPMC Hamot
Pre-Admission
Screening Pre-Operative
Order Sheet**



D-14-85 (01-20-12)

UPMC Hamot