



Wellspan Pre-Op Testing Requisition

Patient Instructions:

Visit www.wellspan.org for locations and hours of operation

Please bring photo ID and insurance card.

Date to be done: _____

Confirmation #: _____

If fasting is required [marked with (F)], please do not eat or drink (except for water) for 10-12 hours prior to test

↓↓ All Asterisk (*) fields are required (please print). Complete ALL fields for specimen drop-offs ↓↓

| | | | | | | | | | | | | | |
|--|-------|------|-----------|--|---|------------------------|---|--|---|-------------------------|---|--|--|
| Patient Full Name* | | DOB* | | Sex (Circle)* | | SSN or MRN (Circle) | | | | | | | |
| Last | First | MI | M | M | D | D | Y | Y | Y | M | F | | |
| Practice Name and Location* | | | | Patient Address | | | | Collected By: Name _____ Date _____ Time _____ | | | | | |
| Ordered By (Printed)* Assumes responsibility for tests ordered | | | | Add'l copy to: (Physician Full Name) does not remove ordering physician responsibility or guarantee receipt of results | | | | Attach Insurance Info | | | | | |
| Last | First | MI | Last | First | MI | | | | | Additional Instructions | | | |
| Physician Signature* | | | Code Key: | | (F): Fasting Required ❖: Additional info Required *: Required field | | | | | | | | |
| Diagnosis Codes with symptom history must be provided* | | | | | | | | | | | | | |
| ❖ Surgical Date: _____ | | | | | | ❖ Date of Order: _____ | | | | | | | |

**** Important Notice **** Tests preceded by a pound sign (#) have limited coverage. Provide appropriate medical necessity documentation (Diagnosis Codes). The patient may be responsible for payment. Medicare patients may be required to sign an ABN for non-covered services.

| | | | | | | | |
|--|--------------------------------|--|---------------------------------|---|---------------------------------------|---|-------------------------------|
| Routine Testing | | | | Drug Testing ❖ Date/Time Last Dose _____ | | | |
| <input type="checkbox"/> Blood Gas (Arterial) | ABG | <input type="checkbox"/> Carbamazepine Lvl (Tegretol) | CARBA | <input type="checkbox"/> BUN | BUN | <input type="checkbox"/> #Digoxin Level | DIGOXIN |
| <input type="checkbox"/> Calcium Level Total | CA | <input type="checkbox"/> Lithium Level | LI | <input type="checkbox"/> #CBC Without Diff | WCBC | <input type="checkbox"/> Phenobarbital Level | PHENOBARB |
| <input type="checkbox"/> Creatinine | CREAT | <input type="checkbox"/> Phenytoin Level (Dilantin) | DILANTIN | <input type="checkbox"/> Electrolytes (CO ₂ , Cl, Na, K) | LYTES | <input type="checkbox"/> Theophylline Level | THEO |
| <input type="checkbox"/> #Glucose Level | | <input type="checkbox"/> Valproic Acid Level (Depakote) | VPA | <input type="checkbox"/> Fasting (F) | GLUF | Blood Bank Testing (Can be collected up to 21 days prior to surgery*) ❖ Surgical Date: _____ | |
| <input type="checkbox"/> Random | GLUR | <input type="checkbox"/> Packed Red Blood Cell Order (leukoreduced) (Number of units, Special Requirements and Indication must be completed) | | <input type="checkbox"/> #Hemoglobin A1c (Glycohemoglobin) | HGB A1C | Special Requirements (select all that apply): | |
| <input type="checkbox"/> Hepatic Function Panel (TBILI, DBILI, AST, Alk Phos, ALT, Alb) | LF | <input type="checkbox"/> Irradiated | <input type="checkbox"/> Washed | <input type="checkbox"/> #Pregnancy BHCG Quant | PREG | <input type="checkbox"/> Split: volume _____ mL | <input type="checkbox"/> None |
| <input type="checkbox"/> #Prothrombin Time / INR | PT | Indication: Pre-Op | | <input type="checkbox"/> #TSH | TSH | <input type="checkbox"/> Type and Screen | TNS |
| <input type="checkbox"/> Urinalysis (Microscopic performed if indicated) ❖ | UA | <input type="checkbox"/> Tube to Hold (no earlier than 3 days prior to surgery) | BB HOLD | <input type="checkbox"/> Midstream | <input type="checkbox"/> Indwell Cath | <input type="checkbox"/> Straight Cath | |
| <input type="checkbox"/> Random | <input type="checkbox"/> Cysto | <input type="checkbox"/> Other _____ | | Additional Laboratory Tests | | | |
| <input type="checkbox"/> MSSA/MRSA Screen Pre-op – Nasal | | <input type="checkbox"/> _____ | | | | | |
| <input type="checkbox"/> _____ | | <input type="checkbox"/> _____ | | | | | |
| Imaging and EKG | | | | This Section Lab Use Only: | | | |
| <input type="checkbox"/> Chest X-Ray – PA and Lateral | | ❖ In the last (3) three months has the patient: | | | | | |
| <input type="checkbox"/> EKG | | Been pregnant? | | <input type="checkbox"/> Yes [†] | <input type="checkbox"/> No | | |
| | | Had any blood transfusions? | | <input type="checkbox"/> Yes [†] | <input type="checkbox"/> No | | |
| | | Been an IV drug abuser? | | <input type="checkbox"/> Yes [†] | <input type="checkbox"/> No | | |
| † If yes, proceed with all other lab orders, and instruct patient to return 3 days before surgery for blood bank testing | | | | | | | |
| (Send copy to Blood Bank during downtime) | | | | | | | |

Preoperative Testing Guidelines For intermediate and high risk operations only

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|---|---|
| <p>EKG (if not done in last 3 months)</p> <ul style="list-style-type: none"> <input type="checkbox"/> > 50 years old, > 40 years old if smoker <input type="checkbox"/> History of cardiac problems <input type="checkbox"/> Renal failure <input type="checkbox"/> PAD <input type="checkbox"/> CVA <input type="checkbox"/> HTN <input type="checkbox"/> DM <input type="checkbox"/> Sleep apnea <input type="checkbox"/> BMI >35 <p>*active cardiac problems/symptoms require EKG in past 3 weeks</p> | <p>CXR (if not done in last 6 months)</p> <ul style="list-style-type: none"> <input type="checkbox"/> > 65 years old, > 40 years old if smoker <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> High risk surgery <p>*active cardiac/respiratory problems or recent abnormal CXR require repeat in the last 3 weeks</p> |
| <p>Lytes/BUN/Creatinine (within the last month)</p> <ul style="list-style-type: none"> <input type="checkbox"/> > 65 years old <input type="checkbox"/> HTN <input type="checkbox"/> CHF <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Diabetes <input type="checkbox"/> Diuretic use <input type="checkbox"/> Steroid use <input type="checkbox"/> High risk surgery | <p>Glucose (if not done in last 3 months)</p> <ul style="list-style-type: none"> <input type="checkbox"/> > 65 years old <input type="checkbox"/> Family history of DM <input type="checkbox"/> BMI > 35 <input type="checkbox"/> Steroid use <input type="checkbox"/> Diabetics* <p>* fasting glucose in last 3 weeks and consider HgbA1C for all Diabetics if not done in the last 3 months.</p> |
| <p>WCBC (within 1 month)</p> <ul style="list-style-type: none"> <input type="checkbox"/> > 65 years old <input type="checkbox"/> Menstruating female <input type="checkbox"/> CAD <input type="checkbox"/> Renal failure <input type="checkbox"/> History of anemia <input type="checkbox"/> History of bleeding <input type="checkbox"/> History of cancer in last year <input type="checkbox"/> History of unintended weight loss > 10 lbs <input type="checkbox"/> Chronic GI disease (except GERD) <input type="checkbox"/> High risk surgery | <p>Drug levels (if not done in last 3 months or recent change in dose)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Digoxin <input type="checkbox"/> Phenytoin (Dilantin) <input type="checkbox"/> Carbamazepine (Tegretol) <input type="checkbox"/> Lithium <input type="checkbox"/> Theophylline <input type="checkbox"/> Valoric acid (Depakote) <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Drug screen if active use suspected |
| <p>Liver function tests (if not done in the last 6 months)</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of liver disease <input type="checkbox"/> Alcoholism <input type="checkbox"/> Malnutrition <input type="checkbox"/> Metastatic cancer | <p>Calcium (if not done in last 3 weeks)</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of hyperparathyroidism <input type="checkbox"/> Active metastatic cancer |
| <p>Pregnancy test</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menstruating females <p>No pregnancy test required if normal period within 10 days of operation, or urgent pregnancy test done (within 7 days), or signed waiver, or menopausal (no period for 1 year and >50 years old), or prior sterilization.</p> | <p>PT/INR (if not done in the last 3 months)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Liver Disease <input type="checkbox"/> Warfarin use* <p>* in last 3 weeks if stable dosing and DOS if dosing within 5 days of surgery</p> |
| <p>Urinalysis</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urinary symptoms <input type="checkbox"/> Surgeon request | <p>TSH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hypothyroidism and no TSH in last year <input type="checkbox"/> Hyperthyroidism and no TSH in last 3 months |
| <p>ABG</p> <ul style="list-style-type: none"> <input type="checkbox"/> As requested by consultant or surgeon | |