MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
ADMISSIONS NAVHOSPPNCLAINST 6010.9W	03 Dec 2012

LOCAL FORM TITLE *(Optional)*
OB/GYN - PRE-OP ORDERS

1. **Pre-Admit to OB/GYN: then** ☐ APU ☐ MSW ☐ 8E
2. **Date of Surgery:**_____
3. **Staff:**
4. **Diagnosis:**
5. **Procedure:**
6. **Pre-Admit Condition:**
7. **Vital signs:** Upon admission and Q shift
8. **Allergies:**
9. **IV and Pre-Op Meds per Anesthesia**
10. **Diet:** NPO after midnight
11. **Activity:** Up Ad lib
12. **Labs:** ☐ CBC ☐ TSH ☐ PT/INR ☐ BMP ☐ U/A w/micro and culture ☐ UHCG ☐ T-S (RBCs)
13. **Other:** ☐ CXR (Routine) PA/LAT ☐ EKG
14. ☐ Anesthesia consult
15. ☐ Antibiotic on call to OR: _____
16. **DVT Prophylaxis:** ☐ Ted Hose on call to OR ☐ SCDs on call to OR
17. ☐ Betadine Douche in AM at home day of procedure
    ☐ Surgical shower HS night before procedure and morning of procedure
18. ☐ Fleets Plain Adult Enema, Rectal, at HS and in AM prn until clear
19. Verify and witness signed consents

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	