O.R. Booking Form - Pediatric Dental Surgery

Version 3.2 {Nov '08}

ADMISSION INFORMATION

Care Card No.: ______________ Unit No.: __________ History Attached- Yes ☐ Consent Form Attached? ____________

Decision to Operate Date: ______________ Patient Type: __________________ E.L.O.S.: (nights) ____________

Patient Ready Date: ____________ *Reason* *(if different than 'Decision to Operate Date'):* ______________________________

Admitting Diagnosis: ____

Case Type/Priority: (PCATS) ______________________________ Admitting Physician: ____________________________

Ref. Physician: ________________ Family Physician: ________________ Interpreter Req.: ◯ Specify: ____________

Post-Op Location: ____________________ Special Req.: Respiratory Isolation ☐ MRSA ☐ Latex Allergy ☐

Coexisting Medical Conditions or Allergies: ____

PATIENT INFORMATION

Surname: __________________________________ First and Middle Names: ______________________________

Birth Date: (yy/mm/dd) ______________ Sex: _________ Address: ____

City: __________________________________ Province: _______________________ Postal Code: ___________

Main Contact Phone No's: (Home) ____

(Cell) ____ (Work) ______________________________________

Name of Parent / Legal Guardian: ____

SURGICAL PROCEDURE INFORMATION

Procedure (use first line for Primary)	Surgeon	Side

Total Skin-to-Skin Time: (mins) _________________ Turnaround Time: (mins) ___________________

Surgery Date: _____________ Admit Date: _____________ Anaesthesia Req.: __________ Blood Req.: ◯ X-Ray Req.: ◯

Special Equipment: ____

Booking Comments:

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CANCELLATION INFORMATION

Cancellation Date: (yy/mm/dd) ___________	Reason: ___________________	New Surgery Date: ___________ New Admit Date: ___________
Cancellation Date: (yy/mm/dd) ___________	Reason: ___________________	New Surgery Date: ___________ New Admit Date: ___________

Revisions		
	Rev. Date: ___________	Details: ______________________
	Rev. Date: ___________	Details: ______________________
	Rev. Date: ___________	Details: ______________________

Instructions *- Please type in all required information. Press 'Print Form' to obtain hard copy. Forward completed form to O.R. Booking Office at B.C. Children's Hospital: 4480 Oak St., Vancouver, B.C. V6H 3V4 Fax: 604-875-3031*