Patient Name______________________

MR # ___________________________

or Patient Sticker Only

Physician Office Personnel
to complete; fax to

☐ Frick Hospital
724-542-1874
☐ Laurel Surgical Center
724-552-0130
☐ Norwin Medical Commons
724-861-6326
☐ Westmoreland Hospital
724-832-4473

EXCELA HEALTH
PRE-ADMISSION INTAKE SUMMARY

Date Faxed:_____________

Document Faxed:
☐ Sterility consent ☐ H & P ☐ Consent ☐ Orders ☐ Anesthesia Survey ☐ Labs ☐ EKG ☐ X-Ray ☐ Stress Test ☐ Medical clearance ☐ Blood consent

Scheduling

Adm. date: Surgery date: Pre-Adm. Test date: Where:

Attending Physician: Family Physician:	**Admission Category:** ☐ Outpatient (local, ambulatory) - circle ☐ Same Day (scheduled admission after surgery) ☐ SurgiCenter at Westmoreland ☐ Inpatient	**Anesthesia Category:** ☐ Local Only ☐ Local / Sedation ☐ General ☐ Regional	**Post-op bed:** ☐ CCU ☐ ICU ☐ PCU ☐ Med-Surg

Patient Demographics

Patient Name	Social Security Number	DOB:	Age:
Address City State Zip		Sex: ☐ M ☐ F	

Home Phone:___________________________ Work Phone:____________________________ Cell Phone:__________________________________
Where can you be reached the day before surgery between 11 AM and 5 PM?____
If you are not available, may we leave a message on your answering machine? ☐ Yes ☐ No
Who may we give information to if you are not available?____ Phone:______________________

Medical Clearance: ☐ Yes ☐ No Completed ☐ Yes ☐ No By______________________________
Patient Diagnosis: ____
Surgical Procedure: ____
Procedure Code: ____
Special Surgical Needs ____
☐ Assistant______________________________________ ☐ Implants ____
☐ Equipment/Instruments ____
ALLERGIES ☐ Food ☐ Medication ☐ Latex Reactions ____
Weight > 300 pounds? ☐ Yes ☐ No ____
Kg __________ Is the patient in isolation? ☐ Yes ☐ No
Is the patient a diabetic? ☐ Yes ☐ No Does the patient live alone or with an invalid? ☐ Yes ☐ No
Does the patient have transportation? ☐ Yes ☐ No Is the patient using hospital van? ☐ Yes ☐ No

Insurance

Accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other List accident as primary, if applicable: ☐ Yes ☐ No

Accident Date:____________________	Primary	Secondary	Other
Insurance Company	________	________	________
Insurance Group Number	________	________	________
Insurance Policy Number	________	________	________
Subscriber Social Security Number	________	________	________
Employer	________	________	________
Guarantor Name:	________	________	________
Authorization Number:	________	________	________

Authorization Effective Date:_______________
Pre-Certification Required: ☐ Yes ☐ No Investigated? ☐ Yes ☐ No Effective Date:___________________________________
Contact Person ____ Phone Number:______________________

If patient is being admitted please complete the following section

PMH:
☐ Diabetes ☐ Arthritis ☐ Kidney ☐ Seizures ☐ Smoke pack/day________ number of years_______quit date________
☐ Thyroid ☐ Lung ☐ Liver ☐ GI ☐ Obesity ☐ Smokeless tobacco_______amount ______number of years______quit date________
☐ Cancer ☐ HTN ☐ Rheumatic Fever ☐ Stroke/TIA ☐ Pregnant
☐ Heart Medications:____
☐ Thallium Stress Test: Year______ where ________________ ____
☐ Cardiac Catheterization Year______ where ________________ ____
☐ CABG Year______ where ________________ ____
☐ Pacemaker: Manufacturer ________________________________ ____
☐ AICD: Manufacturer____________________________________ ____
Is patient autologus blood donor? ☐ Yes ☐ No
Anesthesia Review: ____
____

Copy sent to: ☐ Credit ☐ SSU ☐ SCW ☐ OR ☐ Admissions
☐ Scheduling ☐ Case Management ☐ OP Registration