Carotid Endarterectomy/Carotid Artery Stent Vascular Surgery PreOp [1605]

Patient Name _____ MRN _____

General

Admission or Observation (Single Response)

( ) Admit to Inpatient	Diagnosis: Admitting Physician: Attending Physician: Level of Care: Patient Condition: Bed request comments: Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.
( ) Outpatient observation services under general supervision	Diagnosis: Admitting Physician: Attending Physician: Patient Condition: Bed request comments:
( ) Outpatient in a bed - extended recovery	Diagnosis: Admitting Physician: Attending Physician: Bed request comments:
[ ] Other	

Nursing

Nursing

[ ] Complete consent for Left Carotid Artery Stent	Routine, Once Procedure: Left Carotid Artery Stent Diagnosis/Condition: Physician: Date of procedure: ***
[ ] Complete consent for Right Carotid Artery Stent	Routine, Once Procedure: Right Carotid Artery Stent Diagnosis/Condition: Physician: Date of procedure: ***
[ ] Other	

Diet

[ ] NPO (After Midnight)	Diet effective midnight, Starting S+1 at 12:01 AM NPO: Pre-Operative fasting options:
[ ] Other	

Labs

Laboratory Today

[ ] CBC with differential	Once, Starting S
[ ] Basic metabolic panel	Once, Starting S
[ ] Prothrombin time with INR	Once, Starting S
[ ] Partial thromboplastin time	Once, Starting S
[ ] Type and screen	Once, Starting S
[ ] Other	

Other Studies

Other Diagnostic Studies

[ ]	PV Transcranial Doppler intracranial arteries complete	Routine, 1 time imaging
[ ]	Other	

Physician Signature _____ Date _____