Surgical Slating Form-Elective

SLATING TO STAMP WHEN THEY RECIEVE

☐Bethesda ☐Boundary Trails ☐Carman ☐Portage ☐ Ste. Anne

Surgeon: ____________________ **Date of referral received:** ____________________

To be completed by medical clinic - Family Physician ____________**Referring Physician** ____________

Patient's Last Name: ____________First Name: ____________ Middle Initial: ________
Date of Birth: ____________ MHSC: ____________ PHIN: ____________ ☐Male ☐Female
Address: ____________________Postal code: ____________
Contact Number: ____________________ Work number: ____________________
Emergency Contact: ____________Relationship____________Contact#_____ ________
Height: ________Weight: ________ BMI: ________ WCB ☐Yes ☐No ☐Sleep Apnea ☐ARO ☐M.H.
Alerts: ☐Diabetic ☐Allergies

To be completed by Surgeon:

Decision to treat (Date of Surgical Consent): ☐ **SDS** ☐ **OUT/ADM** ☐ **INPT**
Admitting Physician____________________Anesthetist Consult Required: ☐ Yes ☐ No
Diagnosis: ____________________
Surgical Procedure: ____________________
Second Joint ☐ Yes ☐ No Second Eye: ☐ Yes ☐ No
Additional Information: ____________________
____
Priority: ☐**Potential CA** (< 2 weeks) ☐**Urgent** (< 4 weeks) ☐**Semi-Urgent** (< 6 weeks) ☐**Elective** (< 26 weeks)
Surgeon's Signature: ____________________

To be completed by Slating Clerk: **SIMS Case #:** ____________________

Surgery Date: ____________Surgery Time: ____________ Time of arrival: ____________
Category: ☐ **A**-Fit & Ready ☐ **B**- Delayed due to Medical ☐ **C**- Delayed due to Personal Reasons
Pre-Admission Clinic Date: ____________PT Date: ____________OT Date: ____________
Anesthetic Consult Date/Time:____________Consulting Anesthetist: ____________
Lab date: ________ X- Ray:____________Group Teaching (joints only): ____________
Slating Clerk Signature: ____________ Anesthetist: ____________

Rebook 1: Surgery date: ____________Surgery Time: ____________Time of Arrival: ____________
Pre-Admission Clinic Date: ____________PT Date: ____________OT Date: ____________
Anesthetic Consult Date/Time:____________Consulting Anesthetist: ____________
Lab date: ________ X- Ray:____________Group Teaching (joints only): ____________
Slating Clerk Signature: ____________ Anesthetist: ____________

Rebook 2: Surgery Date: ____________ Surgery Time: ____________Time of Arrival: ____________
Pre-Admission Clinic Date: ____________ PT Date: ____________OT Date: ____________
Anesthetic Consult Date/Time:____________ Consulting Anesthetist: ____________
Lab date: ________ X- Ray:____________ Group Teaching (joints only): ____________
Slating Clerk Signature: ____________ Anesthetist: ____________

To be Completed by Registration Clerk: **MRN:** ____________________**Visit#:** ____________