Spectrum Health

Referral/Evaluation PRE-PROCEDURE - SURGICAL OPTIMIZATION CENTER (SOC)

Patient Name

DOB

MRN

Physician

FIN

IF YOU HAVE ANY QUESTIONS ABOUT THIS PROCESS: ***CALL:*** **Blodgett Hospital SOC** at 616.774.0276 Fax 616.774.5204
Professional Office Building
1900 Wealthy Street SE, Suite 200 Grand Rapids MI 49506

WEBSITE: **spectrumhealth.org/patient-care/surgical-optimization-center**

PRE-PROCEDURE REFERRAL:

Reason for referring patient for SOC evaluation _____

PROCEDURE INFORMATION:

Date _____

Surgery Location: ☐ Butterworth Hospital ☐ Gerber Memorial Hospital ☐ Ludington Hospital ☐ United Memorial Hospital
☐ Blodgett Hospital ☐ Grand Haven Center ☐ Pennock Hospital ☐ Zeeland Hospital
☐ Big Rapids Hospital ☐ Lake Drive Surgical Center ☐ South Pavilion ☐ _____

Procedure type _____

Anticipated time length: Hour(s) _____ Minutes(s) _____

Anesthesia type: ☐ General ☐ Monitored anesthesia care (MAC) ☐ Spinal ☐ Epidural ☐ Regional ☐ Local ☐ _____

PRE-PROCEDURE: Required testing _____

Evaluation required by _____ (date)

SURGERY PHYSICIAN: Name _____

Address _____

Phone _____ Fax _____

PCP name _____

Include the following information with referral:

- Recent History and Physical
- Imaging
- Laboratory studies
- Patient's insurance and demographic information

Is an interpreter needed? ☐ No ☐ Yes

Comments _____

PRE-PROCEDURE EVALUATION:

EVALUATION RESULTS WILL DETERMINE IF THERE SHOULD BE A PRE-PROCEDURE REFERRAL TO THE SOC.

MEDICAL/HEALTH CONDITIONS:

CHECK ANY THAT APPLY:

- ☐ A current inability to: Walk 2 blocks without rest ***OR*** Walk up 2 flights of stairs without rest
- ☐ Anemia (unless it comes under blood clotting disorders)
- ☐ Angina
- ☐ Anticoagulants/blood thinners (apixaban, Coumadin, Dabigatran etexilate, fondaparinux sodium arixtra, heparin, Lovenox, Rivaroxaban)
- ☐ Atrial fibrillation or heart arrhythmia
- ☐ Chronic pain, requiring morphine sulfate or equivalents greater than or equal to 60 mg daily
- ☐ Coagulopathy/blood clotting disorder/bleeding problems
- ☐ Cardiac valve replacement
- ☐ Diabetes: Either taking insulin, uncontrolled, or history of diabetic ketoacidosis
- ☐ History of venous thromboembolism (VTE) and/or pulmonary embolism (PE)
- ☐ History of heart failure or cardiomyopathy
- ☐ Liver disease: Either cirrhosis, hepatitis, jaundice
- ☐ Obstructive sleep apnea (OSA), diagnosed
- ☐ OSA, suspected (three (3) or more "YES" answers on STOP-BANG Questionnaire)
- ☐ Pacemaker, AICD
- ☐ Renal disease: Either Stage IIIb (eGFR 30-44) or higher ***OR*** End stage renal disease (ESRD) ***OR*** Dialysis
- ☐ Stent (heart or peripheral artery) in the past 12 months
- ☐ Stroke/transient ischemic attack (TIA) in the past 9 months
- ☐ Tobacco, nicotine use
- ☐ Other _____

TIME _____ **DATE** _____ Referring/Evaluating Physician signature _____

Referring/Evaluating Physician (print) _____

FAX THIS REFERRAL TO THE SOC AT 616.774.5204.

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

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