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
1840 Wealthy Street SE, Grand Rapids MI 49506
Fax 616.774.5204

***OR***

**Butterworth Hospital SOC** at 616.267.9823
330 Barclay Avenue NE Suite 104, Grand Rapids MI 49503
Fax 616.267.8414

**PRE-PROCEDURE REFERRAL:**

Reason for referring patient for SOC evaluation _____

**PROCEDURE INFORMATION:**

Date _____

Surgery Location: ☐ Butterworth Hospital ☐ Blodgett 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

Telemedicine visit needed:

☐ Big Rapids Hospital
☐ Pennock Hospital
☐ United Memorial Hospital

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
☐ 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
☐ Liver disease: Either cirrhosis, hepatitis, jaundice
☐ Obstructive sleep apnea (OSA), diagnosed
☐ OSA, suspected (three (3) or more "YES" answers on STOP-BANG Questionnaire)
☐ 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
☐ Other _____

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

Referring/Evaluating Physician (print) _____

***FAX THIS REFERRAL TO THE BLODGETT HOSPITAL SOC AT 616.774.5204 OR THE BUTTERWORTH HOSPITAL SOC AT 616.267.8414.***

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







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