OBSTETRIC ANESTHESIA CONSULT

(PT. Label)

Referring Practitioner: ____________________________ Indication for Consult: ___________________________

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G_____P_____ EDC_________________

Obstetric History:

PMH/PSH:

Past Anesthesia History:

Meds:

Allergies:

Airway Exam:

Relevant Physical Exam/Labs:

Assessment/Plan:

Date: _________________ Signature: ___________________________________ CC: _____________________

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Department of Anesthesiology & Pain Management

To use these forms:

Download and Print to a Local Printer (Nurse's Station, etc) Complete the Form:

By Hand: once completed, photocopy x 2:
1) One Copy to Patient Record
2) One Copy to Spectrum Billing (Interoffice Mail) 3) One to Spectrum Q/A (Interoffice Mail)

By Computer: Some forms are in MS Word format. Thus you can load the form into Word (usually by double-clicking), enter the Text you want, and then Print multiple copies:
1) One Copy to Patient Record
2) If necessary or appropriate: One Copy to Spectrum Billing (Interoffice Mail)
3) If necessary or appropriate: One to Spectrum Q/A (Interoffice Mail)

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