

SURGERY SCHEDULING REQUEST

COVID-19 Environment in Utah

May 13, 2020

Please complete the following to submit for surgical procedure review by the OR Council. Determinations will be based upon Utah level of risk, OR availability, personal protective equipment availability, hospital capacity, and staffing. Please be sure to have patient procedures submitted a week in advance to allow time for appropriate patient screening (that will include virus testing ordered through the screening nurses) to ensure safety of patients, our medical staff, and our hospital staff.

THE H&P SHOULD ACCOMPANY THIS FORM

PHYSICIAN NAME: _____ PROCEDURE DATE: _____

FACILITY (WHERE PROCEDURE WILL BE SCHEDULED): _____ ° H&P Attached

PROCEDURE: _____

PATIENT NAME: _____ DOB: _____

COVID-19 RED	COVID-19 ORANGE	COVID-19 YELLOW
<input type="checkbox"/> Urgent or time-sensitive* <i>(include pertinent history below)</i>	<input type="checkbox"/> Urgent or time-sensitive* <i>(include pertinent history below)</i> or meets following elective criteria: <input type="checkbox"/> Ambulatory (no admission) <input type="checkbox"/> Tier 2 procedure <input type="checkbox"/> BMI < 40 <input type="checkbox"/> Patient score 6-11 <i>(see below)</i>	<input type="checkbox"/> Urgent or time-sensitive* <i>(include pertinent history below)</i> or meets following elective criteria: <input type="checkbox"/> Outpatient or Ambulatory <input type="checkbox"/> Tier 2 procedure <input type="checkbox"/> BMI < 40 <input type="checkbox"/> Patient score 6-15 <i>(see below)</i>

* There is high potential for further harm, morbidity, or mortality for the patient if the procedure is postponed further.

PERTINENT MEDICAL HISTORY: Patient Score _____ Bed Requirement: * inpt * 23-hr * none

Factor	1 point	2 points	3 points	4 points	5 points
Patient Age	<20	21-40	41-50	51-65	>65
Lung Dz (asthma, COPD, CF)	Not present			Minimal (rare inhaler)	>Minimal
OSA	Not present			Mild/Moderate (no CPAP)	On CPAP
CV Dz (HTN, CHF, CAD)	None	Minimal (no meds)	Mild (1 med)	Moderate (2 meds)	Severe (> 2 meds)
Diabetes	No		Mild (no meds)	Moderate (PO meds only)	>Moderate (insulin)
Immunocompromised	No			Moderate	Severe

PROVIDER SIGNATURE: _____ DATE: _____

Facility	Scheduler Liaison	Fax Number
AF Endo	Paula	801-855-3032
AF Main OR	Vickie Templin	801-855-4846
AS Main OR	Teri	801-408-5240
AV Main OR	Marky	801-501-2031
AV Endo	Susan	801-501-6460
AV SC Main OR	Marky	801-501-2031
BR Main OR/Endo	TerriLyn	435-207-4630
CA Main OR	Julia	208-677-6595
CC Main OR	Chandel	435-868-5409
CC Endo	Taylor	435-868-5355
DL Main OR	Marsha	435-864-4980
DX Endo	Whitney Harold	435-251-1589
DX Main OR	Cecelia Vancil	dxorscheduling@imail.org
DXHPC Main OR	Cecelia Vancil	dxorscheduling@imail.org
Filmore Main OR	Kathryn	435-743-6312
Garfield Main OR	Julie	435-616-1510
HV Main OR	Kris	435-657-4365
IM Endo	Missy	801-507-3204
IM Main OR/IMSC	Brandon	801-507-3016
LD Endo	Mallory	801-408-1596
LD Main OR	Teri	801-408-5240
LG Main OR/Endo	Stephanie	435-716-5656
LH Main OR/Endo	Holly	801-543-6233
MK Main OR/endo	Charra	801-387-2400
MS Main OR	Heather	801-387-3664
OR Main OR	Ashlee	801-714-3380
PC Main OR/CPC	Raegan	801-662-2758
PCRV Main OR/CPC	Kellie	801-285-1570
PK Main OR/Endo	Michelle	435-658-6840
RV Endo	Jennifer	801-285-2776
RV Main OR	Kim	801-285-2861
SP Main OR	Laurie	435-462-4146
SV Main OR	Kimberly	435-893-0315
TO Main OR	Traci	801-314-4054
UV Main OR/Surg Center	Teresa	801-357-0999
UV Endo	Karin	801-442-0794