TOSC

# TORONTO OUTPATIENT SURGERY CENTRE

# SURGICAL BOOKING SHEET

**For Office Use Only**

☐ Labwork Obtained *(if required)*
☐ OR Time Allocated
☐ TOSC Medical History Form Received
☐ Equipment Confirmed Available
☐ Patient Consents Obtained

## Scheduling Details & Surgeon Information

**Surgeon Name:** _____ **Name of Surgical Assist:** _____
**Proposed Date of Surgery:** _____ **Requested Time / Duration:** _____
**Office Contact Person:** _____ **Office Contact Phone / Fax:** _____

## Patient Demographics & Consent

**Patient Name (Last, First):** _____ **Date of Birth** _____
**Health Card :** _____ **Version Code:** ____ **Phone Number:** _____
**Street Address:** _____
**City** _____ **Province** _____ **Postal Code** _____

**Consent Signed:** ☐ Yes ☐ No **Pre-Op Questionnaire Completed:** ☐ Yes ☐ No

## Surgical Procedure Details

**Primary Diagnosis:** _____ **Secondary Diagnosis:** _____
**Proposed Procedure:** _____
**OHIP Component?** ☐ Yes ☐ No **Relevant Billing Code(s):** _____
**Anesthesia Type:** ☐ General ☐ IV Sedation / Twilight (MAC) ☐ Local **Specimens?** ☐ Yes ☐ No

## Pre-Admission & Medical History

**Anesthesia Pre-Assessment Required?** ☐ Yes ☐ No
**Allergies**: _____ **Specialist Reports?** ☐ Yes ☐ No - If Yes, specify: _____
**Relevant Medical History:** _____

## Equipment & Specific Requirements

**Positioning Needs (ex. prone, supine, lateral):** _____
**Specialized Equipment / Supplies Needed:** _____
_____

## Checklist

| | | |
|---|---|---|
| Bloodwork & ECG | ☐ Attached | ☐ To Be Sent |
| Medical History Form | ☐ Attached | ☐ To Be Sent |
| Patient Consents | ☐ Attached | ☐ To Be Sent |
| Other Reports | ☐ Attached | ☐ To Be Sent |

*(specify)* _____