Alberta Health Services

Day Procedure or Treatment Post Recovery Bed Request

(For stable patients requiring a short stay in hospital post day procedures or treatments)

Last Name	
First Name	
PHN#	Birthdate *(dd-Mon-yyyy)*

Requesting Physician		
Phone	Fax	Pager
Family Physician	Phone	Fax

Day Medicine Department Use Only

Privileges Confirmed ☐Yes ☐No *If no, procedure cannot be booked - notify requesting physician.*

Day Medicine/DI Department Use Only - Complete and Confirmed

MRP & Date Confirmed ☐Yes ☐No *If no, procedure cannot be booked - notify requesting physician.*

Documentation Included ☐Yes ☐No *If no, return with deficiencies circled.*

For Day Medicine Treatment Only – Call Day Medicine Treatment for Date *(numbers listed on reverse)*

Confirmed Date *(yyyy-Mon-dd)* _____

Most Responsible Physician *(MRP)*

Requesting Physician or Designate will be the MRP on the day of procedure and must be available on the day of procedure to consult with health care team as needed. Fax-Back Confirmation Required for DI Referrals.

Requesting Physician is MRP

☐Yes → *MRP contact information must be provided and confirmed on Fax-Back Form*

☐No → *Designate MRP name/consult service and contact info must be provided and confirmed on Fax-Back Form*

Additional Information

Alternate Decision Maker ☐ No ☐ Yes ↓ *(if yes, attach supporting documentation, and complete information below)*

Name of Alternate Decision Maker		Relationship
Home Phone	Work Phone	Cell Phone

Interpreter Required ☐ No ☐ Yes If yes, Specify Language _____

Caregiver Attending ☐ No ☐ Yes Name _____

Isolation Precautions ☐ No ☐ Yes

Type ☐ Contact ☐ Droplet ☐ Airborne, for _____

Patient Care Orders *(Medications, Discharge Orders)*

Goal of Care Designation *(or indicate applicable care level as discussed with patient)*

☐ R1 ☐ R2 ☐ R3 ☐ M1 ☐ M2

☐ C1 ☐ C2 ☐ Other _____

Suspected or confirmed cancer ☐ No ☐ Yes

Requesting Physician Name *(print)*	Signature	Date *(yyyy-Mon-dd)*

Instructions for Completion

1. **Privileges and Most Responsible Physician**

   - ☐ **The Requesting Physician or Designate is the Most Responsible Physician (MRP)** on the day of the procedure and must be available by phone or on site on the day for the medical management of the patient while in hospital. This will be confirmed before the procedure is booked.
   - ☐ **For Day Patients:** Should admission to acute care become necessary, and the MRP does not have hospital inpatient admitting privileges or is unable to attend, the MRP will make arrangements for an admitting physician, consultant, or hospitalist to assume care, following the site Appropriate Responsible Physician admission guidelines (see link). This will take place during a physician to physician conversation between the MRP and the physician assuming care. http://iweb.calgaryhealthregion.ca/departments/em/quality_managment_clinical_practice_guidelines/admission_guidelines.htm
   - ☐ **For Day Medicine Referrals:** The Requesting Physician as MRP, or MRP Designate, must have site-specific privileges (inpatient admitting privileges or Day Medicine privileges). These are acquired through the applicable Clinical Department. Family physicians contact Department of Family Medicine at fm-appt@albertahealthservices.ca or phone 403-955-9227 to obtain the appropriate privileges. Family physicians may receive this privilege through their Community Primary Care Section appointment, with the addition of Day Medicine/Day Surgery as an activity at the appropriate acute care site.

2. **Documentation**

   - ☐ Complete the Day *Procedure or Treatment Post Recovery Bed Request Forms* - all fields, plus History and Physical (via this form or dictated report – current within past 12 months).
   - ☐ Complete and sign *Patient Care Order(s)* for procedure/medication/infusion (next page). Note: transfusion orders must be accompanied by completed consent form for blood products, invasive procedures, and/or phlebotomies prior to Day Medicine appointment. Procedures under General Anaesthetic require discharge orders.

3. **Other Required Information**

   - ☐ If **isolation precautions are necessary**, notify Day Medicine or Day Surgery, including the type of precautions needed – contact, droplet and/or airborne.
   - ☐ If patient is on **anticoagulant**, include **INR** results and date.
   - ☐ If there is a **language barrier and a translator** is necessary (e.g. for patient education and/or to obtain consent), indicate language spoken.
   - ☐ If **assistance with Activities of Daily Living** is anticipated during the stay in Day Medicine or Day Surgery, a **caregiver** must be arranged by Requesting Physician.
   - ☐ **Diabetics** are to receive additional instruction (e.g. when to take hypoglycemic agents/insulin if NPO for procedure), and are to be instructed to bring their medications.
   - ☐ **Infusion therapies are administered in a chair / recliner** in Day Medicine; stretcher beds in Day Medicine are limited to specific indications only.

   Note: Notify Day Medicine/Day Surgery/DI, at least 24 hours in advance if therapy or procedure is cancelled to allow for other urgent patient bookings.

Day Medicine Units By appointment only Monday – Friday (excluding stats)	**Foothills Medical Centre** Phone: 403-944-1436 Fax: 403-944-4434 Hours: 0700 – 1900	**Peter Lougheed Centre** Phone: 403-943-4592 Fax: 403-250-3157 Hours: 0700 – 1900	**Rockyview General Hospital** Phone: 403-943-3797 Fax: 403-252-6382 Hours: 0730 - 1915	**South Health Campus** Phone: 403-956-1270 Fax: 403-956-1298 Hours: Please contact

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Patient Care Orders Continued *(Medications, Discharge Orders)*

☐ Day Medicine *(attach additional orders as necessary)*

- ☐ Recurring ⟶ History and Physical required on first referral, if orders change or annually, whichever is first
- ☐ New ⟶ History and Physical is required each request.

☐ Patient undergoing General Anaesthetic

- ☐ Yes ⟶ Discharge orders **must** be included
- ☐ No ⟶ Discharge orders may be included on this form.

☐ Contact Anesthesiologist for problems related to General Anesthetic

☐ Interventional Radiology *(no further orders needed – Radiologist will do)*

☐ See attached Orders

Requesting Physician Name *(print)*	Signature	Date *(yyyy-Mon-dd)*
Nurse Name		Contact Number