**Midland Memorial Hospital, Midland, TX, 79701**

Centralized Scheduling

Phone: (432)221-2300 Fax: (432)221-4926

**Thoracentesis/Paracentesis Order Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis code: \_\_\_\_\_\_\_\_\_\_\_ Requesting Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure Requested:** □ One-time □ PRN (standing order is good for six months)

**□ Thoracentesis** □ right □ left

**□ Paracentesis**  \*IV albumin: □ 25g □ 50g □ no albumin Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Diagnostic and Therapeutic □ Therapeutic only** (fluid will be discarded without lab analysis)

**□ Fluid Analysis (required for diagnostic)**

□ cytology/pathology □ protein □ AFB

**□** body fluid culture (incl. aerobic, gram stain, C&S) □ glucose □ fungal culture

□ anaerobic □ amylase □ LDH

□ cell count w/ diff □ albumin □ eosinophils

 □ pH (pleural fluid) **□** other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Procedure labs** □ PT, INR, PTT, CBC **Frequency of labs:** □ Draw labs at each visit □ Draw labs every 90 days

 \*\*Lab work is required every 90 days unless recent results are available

**Post-procedure imaging** (required for thoracentesis only) □ 1 view chest XR

**Previous imaging?** □ yes □ no **Where:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please have patient bring outside images to procedure appointment.

**Medication list included?** □ yes □ no (Patient will not be scheduled until med list is received)

**Blood thinners?** □ yes □ no If yes, Medication name/dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hold Blood Thinners for \_\_\_\_\_\_days prior to the procedure and \_\_\_\_\_\_ days after the procedure.

**Can patient consent?** □ yes □ no If no, name of POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact # \_\_\_\_\_\_\_\_\_\_\_

**Provider Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Unless requested STAT by ordering provider, we will contact the patient to schedule once we have received a completed order.