

ENT SURGEON REQUEST CHECKLIST
FAX TO: Boise St. Luke's 381-1485 or Meridian St. Luke's 706-2192

PHYSICIAN:	ASSISTANT:
PROCEDURE:	
PATIENT:	PATIENT AGE:
TODAY'S DATE:	SURGERY DATE:

<p style="text-align: center;">POSITION/APPROACH</p> <input type="checkbox"/> REVERSE BED <input type="checkbox"/> SUPINE <input type="checkbox"/> PRONE <input type="checkbox"/> LATERAL <input type="checkbox"/> RIGHT ↑ <input type="checkbox"/> LEFT ↑ WITH: <input type="checkbox"/> TOWEL ROLL <input type="checkbox"/> BEAN BAG <p style="text-align: center;">SIDE</p> <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL	<p style="text-align: center;">IMPLANTS</p> <input type="checkbox"/> COCHLEAR <input type="checkbox"/> BAHA <input type="checkbox"/> GREY <input type="checkbox"/> BROWN <input type="checkbox"/> BLACK <input type="checkbox"/> PORPS/TORPS <input type="checkbox"/> EPIDISC <input type="checkbox"/> EPIFILM <input type="checkbox"/> CATALANO LACRIMAL PROBE SET <input type="checkbox"/> VAGUS NERVE STIMULATOR <input type="checkbox"/> BOSTON THYROPLASTY SYSTEM <input type="checkbox"/> RADIESSE (INJ. HYDROXYAPATITE)	<p style="text-align: center;">RETRACTORS</p> <input type="checkbox"/> SEWELL RETRACTORS <input type="checkbox"/> JENNINGS MOUTH GAG <input type="checkbox"/> DAVIS CROWE MOUTH GAG <input type="checkbox"/> DINGMAN MOUTH GAG <input type="checkbox"/> MILLARD DINGMAN MOUTH GAG <input type="checkbox"/> MOLT MOUTH GAG <input type="checkbox"/> BOSTON ARM <input type="checkbox"/> BECK'S LARYNGOSCOPE HOLDER <input type="checkbox"/> TOBEY (LEWEY) LARYNGOSCOPE HOLDER
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PATIENT MONITORING
<input type="checkbox"/> FOLEY <input type="checkbox"/> FIBEROPTIC INTUBATION <input type="checkbox"/> JET VENTILATOR <input type="checkbox"/> LASER ET TUBE SIZE _____ <input type="checkbox"/> NIM

<p style="text-align: center;">X-RAY</p> <input type="checkbox"/> C-ARM <input type="checkbox"/> FLAT PLATES <p style="text-align: center;">OTHER</p> <input type="checkbox"/> AUDIOLOGIST (ELKS) <input type="checkbox"/> EEG (INTERROGATION)	<p style="text-align: center;">EQUIPMENT</p> <input type="checkbox"/> LEICA MICROSCOPE <input type="checkbox"/> ZEISS ENT MICROSCOPE <input type="checkbox"/> VIDEO <input type="checkbox"/> BRAINLAB <input type="checkbox"/> CO2 LASER	<p style="text-align: center;">POWER</p> <input type="checkbox"/> ANSPACH BURS _____ <input type="checkbox"/> SKEETER BURS _____ <input type="checkbox"/> COBLATOR BLADE _____ <input type="checkbox"/> XOMED BLADE _____ <input type="checkbox"/> HUMMER BLADE _____
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INSTRUMENTS
<input type="checkbox"/> MYRINGOTOMY TRAY <input type="checkbox"/> EAR INSTRUMENTS <input type="checkbox"/> COCHLEAR INSTRUMENTS <input type="checkbox"/> BAHA INSTRUMENTS <input type="checkbox"/> NASAL SET <input type="checkbox"/> SINUS SET <input type="checkbox"/> PED SINUS FORCEPS <input type="checkbox"/> RHINOPLASTY SET <input type="checkbox"/> FESS SET <input type="checkbox"/> NASAL LACRIMAL DUCT SET <input type="checkbox"/> CALDWELL LUC <input type="checkbox"/> BRAINLAB INSTRUMENTS <input type="checkbox"/> ENT SUCTION IRRIGATION SET <input type="checkbox"/> PALATE INST <input type="checkbox"/> T & A SET <input type="checkbox"/> VOCAL CORD INJECTION SET <input type="checkbox"/> TRACHEOSTOMY SET <input type="checkbox"/> ADULT BRONCH SET <input type="checkbox"/> PEDIATRIC BRONCH SET <input type="checkbox"/> THYROID SET <input type="checkbox"/> ARCH BAR SET <input type="checkbox"/> KLS MARTIN SET <input type="checkbox"/> SYNTHES CRANIOFACIAL SET <input type="checkbox"/> SYNTHES MANDIBULAR SET <input type="checkbox"/> SYNTHES RESORBABLE SET

<p style="text-align: center;">TRACH TUBES</p> <input type="checkbox"/> SHILEY ADULT TRACH TUBES SIZE _____ <input type="checkbox"/> SHILEY PED. TRACH TUBES SIZE _____ <input type="checkbox"/> PORTEX TRACH TUBES SIZE _____ <input type="checkbox"/> METAL TRACH TUBES SIZE _____ <input type="checkbox"/> BIVONA TRACH TUBES SIZE _____ <input type="checkbox"/> OTHER _____	<p style="text-align: center;">HEMOSTATICS</p> <input type="checkbox"/> AVITENE <input type="checkbox"/> FLO-SEAL <input type="checkbox"/> GELFOAM <input type="checkbox"/> GELFILM <input type="checkbox"/> INSTAT <input type="checkbox"/> SURGICEL OTHER NEEDS: _____ _____ _____
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