

**ST. LUKE'S REGIONAL MEDICAL CENTER
ORTHO SURGERY REQUEST CHECKLIST**

PHYSICIAN:	ASSISTANT:
PATIENT:	SURGERY DATE:
PROCEDURE:	

<p align="center"><u>POSITION</u></p> <input type="checkbox"/> SUPINE <input type="checkbox"/> PRONE <input type="checkbox"/> LATERAL <input type="checkbox"/> RIGHT ↑ <input type="checkbox"/> LEFT ↑	<p align="center"><u>TABLE</u></p> <input type="checkbox"/> REGULAR ELECTRIC BED <input type="checkbox"/> OSI FRACTURE TABLE <input type="checkbox"/> AMSCO FRACTURE TABLE <input type="checkbox"/> CAPTAIN'S CHAIR <input type="checkbox"/> OSI FLAT RADIOLUCENT <input type="checkbox"/> TOWER	<p align="center"><u>BONE GRAFT</u></p> <input type="checkbox"/> DONOR SITE <input type="checkbox"/> ALLOGRAFT _____ <input type="checkbox"/> AUTOGRAFT <input type="checkbox"/> OTHER _____
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PATIENT CARE

 FOLEY HIP SPICA SPLINT FIBERGLASS PLASTER FIBERGLASS FREE ORTHOGLASS

EQUIPMENT

<input type="checkbox"/> C-ARM <input type="checkbox"/> MINI C-ARM <input type="checkbox"/> FLAT PLATE X-RAY <input type="checkbox"/> BEAN BAG <input type="checkbox"/> ZIMMER PULSEVAC <input type="checkbox"/> STRYKER IRRIGATOR	<input type="checkbox"/> LATERAL POSITIONER <input type="checkbox"/> SAND BAG <input type="checkbox"/> ALVERADO LEG HOLDER <input type="checkbox"/> FINGER TRAPS <input type="checkbox"/> TOURNIQUET <input type="checkbox"/> INTRACOMPARTMENTAL MONITOR	<input type="checkbox"/> TIBIAL RODDING PILLOW <input type="checkbox"/> RADIOLUCENT TRIANGLES <input type="checkbox"/> SHOULDER BOOM <input type="checkbox"/> STRYKER TURBO HOODS <input type="checkbox"/> OTHER _____
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<p align="center"><u>POWER</u></p> <input type="checkbox"/> SYSTEM 4/5, CORDLESS <input type="checkbox"/> SYSTEM 2000, CORDLESS <input type="checkbox"/> MIDAS REX <input type="checkbox"/> STRYKER CORDLESS, 4100/4200 <input type="checkbox"/> MICRO AIRE IMPACTOR <input type="checkbox"/> MICRO 100 <input type="checkbox"/> COMMAND II/TPS	<p align="center"><u>BASIC INSTRUMENTS</u></p> <input type="checkbox"/> ORTHO SET <input type="checkbox"/> TOTAL INSTRUMENTS <input type="checkbox"/> ORTHO MINOR <input type="checkbox"/> MICRO HAND SET <input type="checkbox"/> OTHER _____	<p align="center"><u>ARTHROSCOPY</u></p> <input type="checkbox"/> ANKLE <input type="checkbox"/> WRIST <input type="checkbox"/> KNEE <input type="checkbox"/> HIP <input type="checkbox"/> OTHER _____
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SPECIALTY INSTRUMENTS/IMPLANTS

<input type="checkbox"/> LARGE FRAGMENT <input type="checkbox"/> STAINLESS STEEL <input type="checkbox"/> SMALL FRAGMENT <input type="checkbox"/> STAINLESS STEEL <input type="checkbox"/> TITANIUM <input type="checkbox"/> MINI FRAGMENT <input type="checkbox"/> STAINLESS STEEL <input type="checkbox"/> TITANIUM	<input type="checkbox"/> MODULAR HAND SET <input type="checkbox"/> DISTAL RADIUS SET (JUPITER) <input type="checkbox"/> WRIST FUSION SET <input type="checkbox"/> ZIMMER HERBERT/WHIPPLE <input type="checkbox"/> GAMMA NAIL <input type="checkbox"/> COMPRESSION HIP <input type="checkbox"/> SYSTEM _____ <input type="checkbox"/> IM RODDING Femoral/Tibial/ Humeral <input type="checkbox"/> SYSTEM _____	<input type="checkbox"/> INTERNAL FIXATOR <input type="checkbox"/> SYSTEM _____ <input type="checkbox"/> ENDOPROSTHESIS <input type="checkbox"/> SYSTEM _____ <input type="checkbox"/> CANNULATED SCREW SETS <input type="checkbox"/> 3.0 MM <input type="checkbox"/> 3.5/4.0 MM <input type="checkbox"/> 4.5 MM <input type="checkbox"/> 7.0 MM <input type="checkbox"/> 7.3 MM
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<p align="center"><u>TOTAL KNEE</u></p> <input type="checkbox"/> ZIMMER KNEE NEXT GEN <input type="checkbox"/> INTERMEDICS KNEE <input type="checkbox"/> DEPUY KNEE <input type="checkbox"/> OTHER _____ <input type="checkbox"/> REVISION <input type="checkbox"/> SYSTEM _____	<p align="center"><u>TOTAL HIP</u></p> <input type="checkbox"/> ZIMMER HIP <input type="checkbox"/> OSTEONICS HIP <input type="checkbox"/> INTERMEDICS HIP <input type="checkbox"/> S-ROM/J&J HIP <input type="checkbox"/> REVISION <input type="checkbox"/> SYSTEM _____	<p align="center"><u>TOTAL SHOULDER</u></p> <input type="checkbox"/> ZIMMER SHOULDER <input type="checkbox"/> INTERMEDICS SHOULDER <input type="checkbox"/> OSTEONICS SHOULDER <input type="checkbox"/> REVISION <input type="checkbox"/> SYSTEM _____
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MISCELLANEOUS INSTRUMENTATION/COMMENTS:
