

Surgery Scheduling Request Form

Phone: 962-2790 Fax:962-7827

Surgery Date: _____ Start Time: _____ TF __ MU __ NM __

Surgeon: _____ Co-surgeon: _____

Patient Name: _____ Birth Date: _____

Social Security Number: _____ Male ___ Female ___

Level of care: Outpatient/SDC _____ Inpatient/AM admit _____ Room #32 ___

Diagnosis: _____

Procedure: _____

Patient Phone: _____

Patient Address: _____

Insurance Company: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Type of Anesthesia: General _____ Regional _____ M.A.C _____ Local _____

Local/Gen _____

Equipment (Include Implant if Appropriate) _____

C-Arm _____ Jackson Bed _____ Cell Saver _____ Zeiss Microscope _____

Stryker Navigation ___ Aloka ___ Neoprobe ___ O-Arm (if available) _____

Neuro monitoring _____

Known Latex Allergy: _____ Interpreter Needed: _____ Language: _____

_____ Surgeon prefers patient to be seen in Pre-op Assessment Clinic

_____ Medical Clearance Required. PCP: _____

_____ Cardiac Clearance Required. Cardiologist: _____

Office contact: _____ Phone: _____ Date _____

Pre-op Orders

- Initiate Pre-Printed Orders Permit Only
- Will Fax Orders Later
- Test Results From Outside Source To Be Faxed
- ORDERS PER ANESTHESIA
- HGB
- CBC
- CBC WITH DIFFERENTIAL
- METAB (BMP)
- METABC (CMP)
- HCT
- HCT/HGB
- PT
- PTT
- INR
- LIPID PROFILE
- SERUM PREGNANCY TEST
- URINE PREGNANCY TEST
- URINE ANALYSIS
- URINE CULTURE
- EKG
- CHEST X-RAY
- TYPE AND SCREEN
- TYPE AND CROSS _____ UNITS
- CONSULT DR. _____

ADDITIONAL

ORDERS: _____

Physician Signature: _____

Please include a copy of the patient's insurance card and drivers license

Thank you, we appreciate your business!