Facility:	Surgery Scheduling #:	Surgery Fax #:
Patient Name (Last, First, Middle Initial):		
Address (Street, City, State, Zip):		
Phone:	If interpretation needed, what language?	
Birth Date:	Age:	Sex:	Social Security:
Insurance (Primary):	Policy number:	
Pre Auth #:		
Patient Email Address:		

Is the surgery urgent?		Yes		No	Comments:			
Is the patient pregnant?		Yes		No	Gestational Age:	OB Provider:		

Surgeon:	Surgery Date:	Time Dr. Avail:
Procedure(s):		
Diagnosis:		
ICD 10 Code(s):		
CPT Code(s):		

Surgical Side		Right		Left		Bilateral	
Diabetic Patient?		Yes		No	Type *(diet, oral, insulin)*:		
If patient is age 18 or younger, what is the pediatric weight?							
Labs done in office?		Yes		No	If yes, fax results with this form		
Due to a device recall?		Yes		No	Comments:		
Due to a warranty issue?		Yes		No	Comments:		
AICD?		Yes		No	Model:		
Pacemaker?		Yes		No	Model:		

Referring Physician								
Admit Type:		Outpatient		Inpatient		AM Admit for Inpatient stay		Extended Observation (outpatient in a bed)

Estimated Length of Surgery in Minutes:					Requested Pain Nerve Block Options:	
Anesthesia Type:					Continual Nerve block infusions	Epidural Continuous
General	Mac	Spinal	Local	IV Reg	Local Anesthetic infusion	Single Nerve Block

Equipment Requests	C-Arm		O-arm	Xray	Laser	Spinal Anesthesia	Other	
	Lg	Mini						
Frozen Section								

Special Physician Requests (*labs, blood, implants not covered in standing orders – surgeon must sign and date this form as order for chart*)
Special Instructions:

Physician Signature/Credentials	Date	Time