Lifespan

# Surgical Services Scheduling/Booking Form

Date of Submission:

## Patient Data

Name: SSN: Sex: M F Birth Date:

Address: City: State: Choose One Zip:

Home phone: Work phone: Mobile phone: Other phone:

Medical Record # (If Known): Religion:

## Surgical Information

| | | |
|---|---|---|
| Procedure Date:<br>Requested Time: | Location: Choose an item. | Surgeon: |
| Patient Class: Choose an item. | Add on case? ☐ | Pre-op Diagnosis Code: |
| Procedure: | | Procedure CPT Code: |
| Laterality: Choose an item. | Anesthesia: Choose an item. | Estimated Time of Procedure: |

## Staff/Equipment/Supplies

| | | |
|---|---|---|
| PAT Visit Needed? ☐<br>Date: | Preferred spoken language: | Preferred written language: |
| Interpreter needed? ☐ | Staff Special Needs: Choose an item.<br>Assistant Name: | Anesthesia Equipment: Choose an item. |
| Table Special Needs: Choose an item. | Implants Needed: ☐ | Vendor Notified: ☐ |
| Vendor Name: | Radiology Special Needs Choose an item. | Specific Laser Needed Choose an item. |

## Special Considerations

| | | | |
|---|---|---|---|
| ☐ Patient above 350 lbs (159 kg) | ☐ Latex Allergy | ☐ Sleep Apnea | ☐ Special Testing Required |
| ☐ Hx Pseudocholinesterase deficiency | ☐ Hx Difficult Intubation | ☐ IDDM | ☐ Hx Malignant Hyper-thermia |
| ☐ Pacemaker/Defibrillator | | | |
| Post-op Destination<br>Choose an item. | Special Needs: | Isolation Precautions:<br>Choose an item. | Physician/LIP must place isolation order in Epic to place patient on precautions |

## Preadmission Information

| | | |
|---|---|---|
| Primary Care Provider: | PCP Phone: | PCP Group: |
| Patient Employer: | Patient Employment Status: Choose an item. | Type of Guarantor Account: Choose an item. |
| Responsible for Guarantor Account<br>Choose an item. | Worker's Compensation<br>Date of Injury: | Guarantor Name (if not patient): |
| Guarantor Sex (if not patient): | Guarantor Birth Date (if not patient): | Guarantor Address (if not patient): |
| Guarantor SSN (if not patient): | Guarantor Employer (if not patient): | Guarantor Employment Status: Choose an item. |
| Primary Coverage (Payor): | Primary Coverage Address: | Primary Coverage Phone: |
| Coverage Plan: | Primary Coverage Subscriber ID: | Subscriber Name (if not guarantor or patient): |
| Subscriber SSN (if not guarantor or patient): | Subscriber Sex (if not guarantor or patient): | Member ID (Patient): |
| Secondary Coverage (Payor): | Secondary Coverage Address: | Secondary Coverage Phone: |
| Coverage Plan: | Secondary Coverage Subscriber ID: | Subscriber Name (if not guarantor or patient): |
| Subscriber SSN (if not guarantorкpt): | Subscriber Sex (if not guarantorкpt): | Member ID (Patient): |

Date: _____ Time: _____ Print Name: _____ Signature: _____