Lifespan

Surgical Services Case Request Form

Date of Submission:

Patient Data

Name: SSN: Sex: M ☐ F ☐ Birth Date:

Address: City: State: Choose an Item Zip:

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

Patient Currently Resides in: Facility Name: Choose an Item Religion: Email:

Other:

This is a Pediatric patient ☐ Y

Surgical Information

Procedure Date: Requested Time:	Location: Choose an item	Surgeon:
Patient Class: Choose an Item	Add on case? ☐	Anesthesia: Choose an item Other:
Procedure:		Laterality: Choose an item
Pre-op Diagnosis Code:	Procedure CPT Code:	Estimated Time of Procedure:
Pre-op Diagnosis Description:	Was this a trauma case as defined by NHSN or this operation a result of traumatic injury (initial injury or sequalae)? ☐ Y ☐ N *NHSN definition: Operative procedure performed because of blunt or penetrating injury to the patient.*	

Patient Status			
	☐ I Normal healthy Patient	☐ II Patient with mild systemic disease	☐ III Patient with severe systemic disease
	☐ IV Patient with severe systemic disease that is constant threat to life	☐ V Moribund patient who is not expected to survive without operation	☐ VI Declared brain-dead patient whose organs are being removed for donor purposes

Has the following clearance been completed?

☐ Cardiac	☐ Geriatric	☐ Hematology	☐ Medical	☐ Pulmonary	☐ Other	☐ Pediatric MAP	☐ N/A

Staff/Equipment/Supplies

PAT Visit Needed? ☐ Virtual PAT preferred? ☐ ☐ Date:	Preferred spoken language:	Preferred written language:
Interpreter needed? ☐	Staff Special Needs: Choose an Item 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 Needs:		

Special Considerations

☐ Patient has a latex allergy	☐ Patient has sleep apnea	☐ Hx Difficult Intubation (Notify Anes dept)	☐ Hx Malignant Hyperthermia (Notify Anes dept)
☐ Hx Pseudocholinesterase deficiency	☐ IDDM – Needs earlier case time	☐ Patient weighs over 159kg (350lb)	Special Testing Required
☐ Patient has a Pacemaker/Defibrillator	☐ Chlorhexidine Allergy		
Post-op Destination Choose an Item	Expected length of stay (in days):	Precautions: Choose an Item *Physician/LIP must place isolation order in Epic to place patient on precautions Isolation*	

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 Choose an Item	Worker's Compensation 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 guarantor/pt):	Subscriber Sex (if not guarantor/pt):	Member ID (Patient):

Print Name

Date_____

By signing here, I hereby attest and acknowledge that the use of an electronic signatureor manual signature equivalent constitutes the legal equivalent of my manual signature within document.

MD Signature