

ASC OR BOOKING SHEET PHONE # 444-9431 FAX # 444-6452

* Patient's Contact phone day before surgery _____

PATIENT NAME _____ DOB _____ SS# _____

MRN _____ HOME PHONE _____ WORK /CELL _____

INSURANCE _____ AUTH/ REFFERAL# _____

DATE OF SURGERY _____ PHYSICIAN _____ SVC _____

PHYSICIAN'S CONTACT PERSON & PHONE _____

CPT CODE SURGEON'S PROCEDURE SITE/ SIDE

SBUMC PROCEDURE: _____

ICD9 CODE(S) : _____ DURATION OF SURGERY : _____ HR(S)

CHECK THAT ALL APPLY :

XRAY NEEDED _____ LATEX _____ Has Pacemaker _____
DURING SURGERY _____ ALLERGY _____ Pace/Defibrillator _____ DIABETIC _____ PREGNANT _____

COMMENTS/MISCELLANEOUS

SPECIAL EQUIPMENT/IMPLANTS NEEDED FOR PROCEDURE : _____

BREAST SIZERS NEEDED ? _____ **REQUIRED FOR ALL BREAST CASES**

DOES PATIENT NEED POS APPOINTMENT AT SBUMC? YES NO

ASA _____ **ANESTHESIA CONSULT REQUIRED FOR ADULT PATIENT ASA 3 OR PATIENT LESS THAN 18 YEARS ASA 2 OR 3

POS SERVICES NEEDED: PLEASE CHECK THOSE THAT APPLY – FOR SCHEDULING PURPOSES ONLY
****PHYSICIANS MUST USE APPROPRIATE HOSPITAL FORMS FOR ORDERS* * PLEASE FAX ALL TESTING ORDERS TO 444-9536***

POS COMMENTS

ANESTHESIA
CONSULT _____ EKG _____ H & P _____ LABS _____

Is this patient either residing in a facility or group home, mentally disabled or on a ventilator?
If yes, provide details _____

Office use only

OR SCHEDULED FAX **POS SCHEDULED** PREREG _____

CO-PAY/ DEPOSIT/ DEDUCTIBLE _____ BY _____ FINANCIAL APPROVAL AND COMMENTS _____