

ASC OR ORTHOPAEDIC 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 All That APPLY: X-RAY Day of SGY: A) Fluoroscopy LG _____ B) MINI C-ARM _____ C) Flat Plate _____

LATEX ALLERGY _____ DIABETIC _____ PREGNANT _____

Company SIZE OF SCREWS TYPE

IMPLANTS: _____

Removals: _____

Allograft: _____

OTHER SPECIAL EQUIPMENT NEEDED FOR PROCEDURE :

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