SHARP Memorial Outpatient Pavilion

PHONE: (858) 939-5105 **FAX**: (858) 636-2200

☐ **INITIAL BOOKING** ☐ **MODIFIED BOOKING / DESCRIPTION:**

DATE: **FROM:** **PHONE:**

PATIENT INFORMATION REQUIRED FOR ALL CASES **TYPE OR PRINT CLEARLY – NO ABBREVIATIONS**

Last Name: **First Name:**

Address: **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Date of Birth:** **SSN:**

Gender: **Height:** **Weight:**

What's the Patient's BMI per your Pre-Op office visit?

(Patient's with a BMI > 45 requires approval of Medical Director) Click Here for BMI Calculator

☐ **OUTPT** ☐ **SHORT STAY**

Surgeon: **Assistant / Second Surgeon:**

Surgery Date: **Time:** **Length of Procedure:**

Pre-Op Diagnosis: _____

_____ **Primary ICD10:**

IS THIS PROCEDURE TO TREAT OR TO FURTHER DIAGNOSE A CANCER? ☐ **YES** ☐ **NO**

Latex Allergy? ☐ **YES** ☐ **NO**

Laterality: ☐ **LEFT** ☐ **RIGHT** ☐ **BILATERAL** ☐ **N/A**

Surgical Procedure: _____

_____

_____

_____ **Primary CPT:**

ANESTHESIA: ☐ **GENERAL** ☐ **LOCAL/MAC** ☐ **CHOICE** ☐ **PAIN ROOM IV SEDATION**

SPECIAL NEEDS: ☐ **MINI FLUOROSCAN** ☐ **C -ARM** ☐ **FAXITRON**

EQUIPMENT: _____

_____

Imaging Procedure Performed at SHC? ☐ **YES** ☐ **NO** **Performed at SDI?** ☐ **YES** ☐ **NO**

Location Performed: **Date Performed:** **Phone:**

Images to be Printed: ☐ **YES** ☐ **NO**

Outside Images: ☐ **Surgeon to Bring** ☐ **Patient to Bring** ☐ **CD from Office**

ADDITIONAL PATIENT INFORMATION

Insurance: **Authorization #**

Is Patient Pregnant? ☐ **YES** ☐ **NO** **If Yes, How Many Weeks?**

Is the Patient Coming Back from a Skilled Nursing Facility? ☐ **YES** ☐ **NO** **Facility**

FIRST* IN THE LINE UP:** ☐ ***C-PAP ☐ ***SLEEP APNEA*** ☐ ***DIABETIC***

LAST* IN THE LINE UP:** ☐ ***C-DIFF ☐ ***MRSA*** ☐ ***VRE*** ☐ ***ESBL***

PRINT

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