SHARP Coronado Hospital

SURGERY SCHEDULING FORM

Please Fax booking to: 619-502-8555
Call Scheduler to Confirm: 619-522-3728

☐**Initial Booking** ☐**Modified Booking/Description:**_____
DATE: _____FROM: _____ PHONE #: _____

INFORMATION REQUIRED FOR ALL CASES **Print clearly –no abbreviations**

PATIENT LAST NAME: _____FIRST NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE:_____

PHONE NUMBER: (HOME)_____ (CELL PHONE)_____

DATE OF BIRTH: _____/_____/_____ SEX: _____ SSN# _____-_____-_____

☐INPT ☐SHORT STAY ☐OUTPT ☐IN HOUSE RM #: ____

SURGEON: _____

ASSISTANT / SECOND SURGEON: _____

SURGERY DATE: _____/_____/_____ TIME: _____ LENGTH OF PROC: _____

PRE-OP DIAGNOSIS: _____

LATERALITY: ☐ LEFT ☐RIGHT ☐ BILATERAL ☐ N/A
SURGICAL PROCEDURE: _____

_____

IMAGING PROCEDURE:_____

PERFORMED AT SHC: ☐YES ☐NO PERFORMED AT SDI: ☐YES ☐NO
LOCATION PERFORMED:_____PHONE #:_____ DATE PERFORMED:_____
IMAGES TO BE PRINTED: ☐YES ☐NO OUTSIDE IMAGES: ☐SURGEON TO BRING ☐PATIENT TO BRING ☐CD FROM OFFICE

ADDITIONAL PATIENT INFORMATION

HEIGHT: _____WEIGHT:_____ BMI:_____ FAMILY PHYSCIAN:_____

LATEX ALLERGY: ☐YES ☐NO METAL ALLERGY: ☐YES ☐NO ISOLATION PRECAUTIONS: _____

PRIMARY LANGUAGE: _____ INTERPRETER: ☐YES ☐NO

INSURANCE INFORMATION

INSURANCE:_____ POLICY #:_____ SECONDARY INSURANCE:_____ POLICY #:_____

AUTHORIZATION #: _____ ☐PENDING ☐NOT NEEDED CPT CODE(S)_____

BOOKING INFORMATION

POSITION: _____ANESTHESIA TYPE: _____

☐X-RAY ☐C-ARM ☐NEW OEC C-ARM ☐FLOUROSCAN: ____ CERTIFIED: ☐YES ☐NO

EQUIPMENT: ☐LASER

SPECIAL EQUIPMENT/SUPPLIES:_____
_____

INSTRUMENTATION/IMPLANTS: _____

REP NEEDED: ☐YES ☐NO

If your patient has any of the following THEY MUST GO FIRST IN THE LINE-UP
DIABETIC MALIGNANT HYPERTHERMIA
If your patient has any of the following THEY MUST GO LAST IN THE LINE-UP
C-DIFF MRSA VRE ESBL TB

Ortho

HIP FRACTURE: _____ANTEGRADE: ☐YES ☐NO RETROGRADE: ☐YES ☐NO TROCHANTERIC: ☐YES ☐NO

TIBIAL/HUMERAL FRACTURES: _____ PROXIMAL: ☐YES ☐NO DISTAL: ☐YES ☐NO

POSITION/EQUIPMENT: _____ COMPANY: _____