SPINE SURGERY SCHEDULING FORM

Phone: (858) 939-3424 Fax: (858) 636-2555

☐**Initial Booking** ☐**Modified Booking/Description:**_____

DATE: _____FROM: _____ PHONE #: _____

INFORMATION REQUIRED FOR ALL CASES	**TYPE –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: _____ PROCTOR ☐YES ☐NO_____

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

PATIENT E-MAIL:_____HEIGHT: _____WEIGHT:_____

INSURANCE CARRIER: _____ INSURANCE ID#_____

NAME OF SUBSCRIBER IF OTHER THAN PATIENT:_____DOB:_____

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

_____

WORKMANS COMP CARRIER: ☐YES ☐NO

ADMISSION TIME: _____☐BRACE TYPE:_____ ☐VENDOR: _____ ☐PRE-OP ☐ POST-OP

LATEX ALLERGY: ☐YES ☐NO ISOLATION PRECAUTIONS: _____PRIMARY LANGUAGE: _____ INTERPRETER: ☐YES ☐NO

IS PATIENT COMING FROM A SKILLED NURSING FACILITY? ☐YES ☐NO FACILITY:_____

BOOKING INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PREFERRED START TIME: _____

FOLEY: ☐YES ☐ NO ☐ICU BED ☐ANESTHESIA TYPE: _____

INTRAOP MONITORING: ☐SSEP ☐MMEP ☐EEG ☐NUVASIVE ☐ NOT NEEDED ☐OTHER_____

RADIOLOGY: ☐X-RAY ☐NEW OEC C-ARM ☐LONG CASSETTE ☐OTHER: _____ CERTIFIED: ☐YES ☐NO

POSITION: ☐SUPINE ☐PRONE ☐ LEFT LATERAL ☐RIGHT LATERAL ☐OTHER _____

POSITIONER DEVICE: ☐GREEN LIGHT JACKSON (☐ WILSON ☐HALL) ☐ANDREWS ☐MIDMARK (☐MAYFIELD ☐C-FLEX)
☐BERCHTOLD ☐LAM ROLLS

EQUIPMENT: ☐CELL SAVER ☐COOL SUIT ☐MICROSCOPE: (☐LEICA ☐MITAKA) ☐DRILL ☐BRAIN LAB

BONE: ☐AUTOGENOUS ☐ILIAC CREST ☐OTHER _____

ALLOGRAFT: ☐CANCELLOUS ☐OSTOECEL ☐ TRINITY ☐PUREGEN ☐OTHER ALLOGRAFT _____

IMPLANT / INSTRUMENTATION / REP NEEDED:

_____

_____

_____

OTHER: _____

_____

_____

_____

_____

_____

_____

CANCELLATION REASONS IF APPLICABLE

☐Abnormal Labs ☐Case Booked Elsewhere ☐Insurance Doesn't Pay ☐Patient Ate ☐Patient/Family Request/Refused

☐Physician Cancelled (Please Explain):_____

☐Other Cause (Please Explain):_____