SHARP Mary Birch Hospital for Women & Newborns

SURGERY SCHEDULING
Phone: (858) 939-4343 Fax: (858) 636-2700

☐ Initial Booking ☐ Modified Booking/Description:_____FIN#_____

Date:_____ From:_____ Phone Number:_____

INFORMATION REQUIRED FOR ALL CASES **PRINT CLEARLY - PLEASE NO ABBREVIATIONS**

PATIENT LAST NAME:_____ FIRST NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

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

DATE OF BIRTH:_____ LAST FOUR NUMBERS OF SOCIAL SECURITY:XXX-XX-_____

☐ INPATIENT ☐ SHORT STAY ☐ OUTPATIENT ☐ IN HOUSE ROOM NUMBER:_____

SURGEON:_____

ASSISTANT/SECOND SURGEON:_____

SURGERY DATE:_____ TIME:_____ LENGTH OF PROCEDURE:_____

PRE-OP-DIAGNOSIS:_____

LATERALITY: ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ N/A

SURGICAL PROCEDURE:_____

_____

IMAGING PROCEDURE:_____

PERFORMED AT SHARP HEALTH CARE: ☐ YES ☐ NO PERFORMED AT SAN DIEGO IMAGING: ☐ 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

ANESTHESIA TYPE: ☐ GENERAL ☐ LOCAL/MAC ☐ SPINAL ☐ OTHER:_____

BLOOD PRODUCTS:_____ BLOOD PRODUCTS REFUSAL: ☐ YES ☐ NO

PATIENT PREGNANT: ☐ YES ☐ NO HOW MANY WEEKS:_____ DUE DATE_____

NEEDS PAES CONSULT? ☐ YES ☐ NO HEIGHT_____ WEIGHT_____BMI_____ OSA ☐ YES ☐ NO

REASON FOR CONSULT: ☐ MEDS ☐ BLEEDING DISORDER ☐ LOWER BACK SURGERY ☐ MD REQUEST

LATEX ALLERGY: ☐ YES ☐ NO ISOLATION REQUIRED: ☐ MRSA ☐ VRE ☐ TB ☐ OTHER:_____

PRIMARY LANGUAGE:_____ INTERPRETER: ☐ YES ☐ NO

DEAF: ☐ YES ☐ NO INTERPRETER: ☐ YES ☐ NO

IS THIS SURGICAL PROCEDURE TO DIAGNOSE OR TREAT CANCER ☐ YES ☐ NO

BOOKING INFORMATION

	In Room	Open
Novasure	☐	☐
HTA	☐	☐
Thermachoice	☐	☐
Myosure	☐	☐
Resectoscope	☐	☐
Versapoint	☐	☐
Fluid Management	☐	☐
Ultrasound	☐	☐
Berkeley Suction	☐	☐
Colposcope	☐	☐
Vcare	☐	☐
Rumi/Humi	☐	☐
Neoprobe	☐	☐

	In Room	Open
Triad	☐	☐
Harmonic	☐	☐
Everest	☐	☐
Gyrus	☐	☐
Kleppinger	☐	☐
Argon Unit	☐	☐
Firefly	☐	☐
Single Site (DaVinci)	☐	☐
Exparel	☐	☐
Mesh	☐	☐
Sling:_____	☐	☐
Liposuction	☐	☐
Other:_____	☐	☐

OR Case #:_____