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
ATIENT LAST NAME:	FIRST NAME:	
DDRESS:		
TTY:	STATE: ZIP CODE	B:
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 PROCEDURE: PRO		
MAGING PROCEDURE:		
PERFORMED AT SHC: □YES □NO PERFORMED LOCATION PERFORMED:		DATE PERFORMED:
MAGES TO BE PRINTED: □YES □NO OUTSIDE IMA		
ADDITIONAL PATIENT INFORMATION		
HEIGHT: BMI:	FAMILY PHYSCIAN:	
LATEX ALLERGY: □YES □NO METAL ALLERGY:		
PRIMARY LANGUAGE: INTERPRETER:	□YES □NO	
INSURANCE INFORMATION		
NSURANCE:POLICY #:	SECONDARY INSURANCE	B: POLICY #:
AUTHORIZATION #: □PENDING	□NOT NEEDED CPT CODE(S)	
BOOKING INFORMATION		
POSITION:ANESTHESIA TYPE	:	
□X-RAY □C-ARM □NEW OEC C-ARM □FLOUROSCAN	I: CERTIFIED: □YES □NO	
equipment: □Laser		
SPECIAL EQUIPMENT/SUPPLIES:		
NOTED LIMENTE ATTION (TREE) A NITE		
INSTRUMENTATION/IMPLANTS: REP NEEDED: □YES □NO		
	O FIDOR IN THE LINE AR	
If your patient has any of the following THEY MUST GO DIABETIC MALIGNANT HYPERTHERMIA If your patient has any of the following THEY MUST GO C-DIFF MRSA VRE ESBL TB		
HIP FRACTURE:ANTE	EGRADE: □YES □NO RETROGRADE: □]YES □NO TROCHANTERIC: □YES □
TIBIAL/HUMERAL FRACTURES:	PROXIMAL: □YI	ES □NO DISTAL: □YES □NO

____COMPANY: _

POSITION/EQUIPMENT: ___