ST LOUIS EYE SURGERY & Laser Center

# SURGERY BOOKING SHEET

*Revised 01/2017*

❒ **REVISED Surgery Booking Sheet** ❒ **1st Surgery** ❒ **2nd Surgery** ❒ **Rescheduled**

| Procedure Date: | Procedure Time: | Patient Arrival Time: | Duration: |
|---|---|---|---|
| | | | |

**Today's Date**: _____ **Surgeon**: _____ **Scheduler/Contact**: _____

**Patient Name (first-middle initial-last)**: _____

**DOB**: _____ **SSN (required)**: _____ Sex: ❒ Male ❒ Female

**Home**: ( _____ ) _____ **Work**: ( _____ ) _____ **Cell**: ( _____ ) _____

**Other Phone**: ( _____ ) _____ **Best way to reach patient**: ❒ Home ❒ Work ❒ Cell ❒ Other / Family

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**CPT**: _____ **Description**: _____

_____ _____

_____ _____

**ICD-10:** _____ Additional information: ❒ ORA ❒ Toric IOL ❒ Multi-focal IOL

**ICD-10:** _____ Femtosecond laser: ❒ Catalys ❒ LenSx

**Anesthesia Type (CIRCLE ONE)**:

Straight Local

MAC with Retrobulbar

MAC

General

**BCVA (answer for BOTH eyes when anesthesia type is "LOCAL"):** **OD (right)** _____ **OS (left)** _____

**Equipment Needed/Special Instructions**: _____

**Please Answer the Following Statements/Questions**:

❒ YES ❒ NO **Patient has ICD or Defibrillator.**
*If "YES," EP Clearance is required; fax "ICD Patient Clearance" form to (314) 686-4201*

❒ YES ❒ NO **Patient had cardiac stent placement within the past 90 days.**
*If "YES," scheduler should contact the pre/post-op manager immediately at (314) 686-4200*

❒ YES ❒ NO **Patient requires a Medical or Durable Power of Attorney (DPA).**
*If "YES," the patient or patient representative must be instructed by scheduler to fax it to (314) 686-4201 prior to DOS*

❒ YES ❒ NO **English is the patient's primary language.**
*If "NO," what language is primary?* _____

❒ YES ❒ NO **SLESLC should secure a foreign language interpreter for DOS**
*If "NO," who (REQUIRED) will be interpreting for the patient?* _____

❒ YES ❒ NO **SLESLC should secure a deaf interpreter for DOS**
*If "NO," who will be interpreting for the patient?* _____

❒ YES ❒ NO **Should SLESLC speak with someone other than the patient for medical history and financial information?**
*If "Yes," required HIPAA authorization (located within patient brochure) must be attached or faxed to (314) 686-4201*

**PRIMARY INSURANCE INFORMATION**:

**Plan**: _____

**Insured ID No.**: _____

**Group No.**: _____

**Referral/Pre-Cert No. (if applicable)**: _____

**SECONDARY INSURANCE INFORMATION**:

**Plan**: _____

**Insured ID No.**: _____

**Group No.**: _____

**Referral/Pre-Cert No. (if applicable)**: _____

- Patient provided/mailed SLESLC's informational booklet with info. regarding ownership, advanced directives, and patient rights & responsibilities.
- Enlarged photocopies of patient insurance ID cards attached.

**FAX TO (314) 686-4201 • THANK YOU**