SURGICAL POSTING FAX REQUEST

FAX: 301-552-8528   OFFICE: 301-552-0400

Please Print and Complete All Items: NO ABBREVIATIONS

Today's Date   Requested Date of Surgery: Start Time:

North Building/DCAS   Main OR   Endoscopy   Invasive Lab   Surgeon:

Admission Type: Outpatient   AM Admit   Out-PES*   Inpatient (Room#

PATIENT INFORMATION

Last Name: First Name: MI: Sex   Patient's DOB

Guardian (if appropriate):___________________________ Contact #:________________________ Relationship to patient: ____________________________

Current Address: ____ City: _______________________________State:______________ Zip:_______________

Home#: ____ Work#:_________________________________ Cell#:____________________________________

Is this a Nursing home: Assisted Living   Height: Weight: Sleep Apnea?

Will patient use Metro Access on day of surgery?

Pacemaker / ICD?   (If yeas to Pacemaker/ICD) Cardiologist: Phone#:

What is patient's preferred language for health care needs?:

PRE-CERTIFICATION #(if available):

Insurance Company #1   ID#:

Insurance Company #2   ID#:

Primary Care Physician: Phone #:

Procedure	**DIAGNOSIS:** **Procedure(s** EPIDURAL INJECTION LEVELS DATE EPIDURAL #1 @ TIME DATE EPIDURAL #2 @ TIME DATE EPIDURAL #3 @ TIME **Consent to read:** EPIDURAL INJECTION LEVELS If other than historical, provide cut to close time: Anesthesia: Assisting Surgeon:	Laterality CPT Code ICD-9/10 Right Left Bilateral
Physician's Signature	Signature:____ Date ______/______/______ Time:___________________	

Special Equipment and / or Implants Required: If Yes, Provide All Information Below

Vendor rep required: If yes, Name of Rep or Company: Has rep been contacted:

Neuromonitoring: Cellsaver: Harvest / GPS

IDENTIFIY LASER REQUIRED: ULTRASOUND REQUIRED:

Name of Person Completing form: Phone#:   Fax#

Please fax a copy of the patient's insurance card and patient's ID along with your posting sheet.

*Out-PES – Outpatient with a Potential Extended Stay

Form #03-200 (Revised 7/1/14)

Patient's Last Name: First Name: MI:

FOR SURGICAL SCHEDULING OFFICE USE ONLY:

FOLLOW UP QUESTIONS: ____

____

Returned with questions: **Date:**

CONFIRMATION: ________________________________ **SCHEDULER'S INITIALS:** ______________

FAXED DATE AND TIME ____

SPACE RESERVED FOR FOLLOW UP RESPONSES OR UPDATED / CHANGES FROM OFFICE:

UPDATED DATE: ____ CHANGED DATE: ______________________________

UPDATED DATE: ____ CHANGED DATE: ______________________________

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