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

Patient's Last Name:________________________ First Name:________________________ MI: _____ Sex: M F Patient's DOB: ___/___/______

Guardian (if appropriate): _____________________________ Contact #: _________________________ Relationship to patient: ___________________

Patient's Current Address: ____________________________________ City:_____________________________ State:_____________ Zip:__________

Home #: ___________________________________ Work #: _________________________________ Cell #: _________________________________

Is this a Nursing home: □ Yes □ No Assisted Living: □ Yes □ No Pt's Height: ________ Weight: ______ **Sleep Apnea?** Yes No Unknown

Will patient use Metro Access on day of surgery? □ Yes □ No □ Unknown

Pacemaker/ICD? Yes No Unknown (**If yes 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** **Consent to read:** If other than historical, provide cut to close time: ____________________________ Anesthesia: ____ Assisting Surgeon: __________________________________
Physician's Signature	**Signature** ______________________________ **Date:** ________________ **Time:** ___________

Laterality	CPT Code	ICD-9/10
□ Right		
□ Left		
□ Bilateral		

Special Equipment and/or Implants Required: □ Yes □ No **If Yes, Provide ALL Information Below**

Vendor rep required: □ Yes □ No If yes, Name of Rep or Company: ________________________________ Has rep been contacted: □ Yes □ No

Neuromonitoring: □ Yes □ No Cellsaver: □ Yes □ No Harvest/GPS: □ Yes □ No

IDENTIFY LASER REQUIRED: ___________ ULTRASOUND REQUIRED: □ Yes □ No

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**

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 INFO: _____________________________________ **CHANGED INFO:** ____

____ ____