# Rush University Medical Center - SURGICAL RESERVATION FORM

1653 W. Congress Parkway, Chicago, IL 60612

**The following information is REQUIRED. The Reservation Form cannot be processed without this information.**

Patient Name: ______________________ ______________________
Last First MI

MR# (if available) ______________________

Sex: ________ Date of Birth: ______________ S.S.#: ______________

Patient Address: ______________________ Work ph: ______________

______________________ Home ph: ______________

______________________ Mobile ph. ______________

Requested Surgery Date: ________ Requested Surgery Time: ________ Case Order: ________ Admission Date: ________ Anticipated LOS: ________

Surgeon: ______________________ Surgeon Office Phone: ______________

Patient Class: ☐ In-house/ED ☐ Inpatient/Admit after Surgery ☐ Observation ☐ Outpatient

Pre-Op Diagnosis ______________________ Est. length of surgery ________

Add on Case? ☐ Yes ☐ No Add on Date: ______________ Rescheduled: ☐ Yes ☐ No

Procedure(s): ______________________

(include code and description) ______________________

______________________

LRB (laterality) ☐ Left ☐ Right ☐ Bilateral ☐ N/A Anesthesia Type: ______________

Additional Procedure Requests (equip, supp, set-up, etc.) ______________________

______________________

______________________

Admit Bed Pef: ______________ Weight: ________ Isolation status? ______________

Latex Allergy? ☐ Yes ☐ No Interpreter Needed? ☐ Yes ☐ No Language? ______________

Were pre-op labs done? ☐ Yes ☐ No If yes, where? ______________ Ph#: ________

Addt'l Tests Required? ☐ Yes ☐ No If yes, what? ______________

Implants needed: ☐ Yes ☐ No Implant System: ______________

Revision? ☐ Yes ☐ No Vendor Notified? ☐ Yes ☐ No

Primary Insurance*: ______________ Secondary Insurance: ______________

Primary Phone #: ______________ Secondary Phone #: ______________

Policy #: ______________ Secondary Policy #: ______________

Group #: ______________ Secondary Group #: ______________

Auth/Cert #: ______________ Secondary Auth/Cert #: ______________

Devices**: ______________

* If Research patient, enter "Research" and complete Research Reservation Form

** Document No Charge Devices or Implants