SHARP Memorial Hospital

SURGERY SCHEDULING

Phone: (858) 939-3424 Fax: (858) 636-2555

☐**Initial Booking** ☐**Modified Booking/Description:**_____

DATE: _____FROM: _____ PHONE #: _____

INFORMATION REQUIRED FOR ALL CASES **TYPE –NO ABBREVIATIONS**

PATIENT LAST NAME: _____FIRST NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE:_____

PHONE NUMBER: (HOME)_____ (CELL PHONE)_____

DATE OF BIRTH: _____ /_____/_____ SEX: _____ SSN# _____-_____-_____

☐INPT ☐SHORT STAY ☐OUTPT ☐IN HOUSE RM #: _____

SURGEON: _____

ASSISTANT / SECOND SURGEON: _____ PROCTOR ☐YES ☐NO_____

SURGERY DATE: _____/_____/_____ TIME: _____ LENGTH OF PROC: _____

PRE-OP DIAGNOSIS: _____

LATERALITY: ☐ LEFT ☐RIGHT ☐ BILATERAL ☐N/A

SURGICAL PROCEDURE:

_____

_____

_____

_____

_____

_____

IMAGING PROCEDURE:_____

PERFORMED AT SHC: ☐YES ☐NO PERFORMED AT SDI: ☐YES ☐NO

LOCATION PERFORMED:_____PHONE #:_____ DATE PERFORMED:_____

IMAGES TO BE PRINTED: ☐YES ☐NO OUTSIDE IMAGES: ☐SURGEON TO BRING ☐PATIENT TO BRING ☐CD FROM OFFICE

ADDITIONAL PATIENT INFORMATION

PATIENT E-MAIL:_____HEIGHT: _____WEIGHT:_____

INSURANCE CARRIER: _____ INSURANCE ID#_____

NAME OF SUBSCRIBER IF OTHER THAN PATIENT:_____DOB:_____

AUTHORIZATION #: _____ ☐PENDING ☐NOT NEEDED CPT CODE(S)_____

_____

WORKMANS COMP: ☐YES ☐NO

LATEX ALLERGY: ☐YES ☐NO ISOLATION PRECAUTIONS: _____PRIMARY LANGUAGE: _____ INTERPRETER: ☐YES ☐NO

IS PATIENT COMING FROM A SKILLED NURSING FACILITY? ☐YES ☐NO FACILITY:_____

IS THIS SURGICAL PROCEDURE TO DIAGNOSE OR TREAT CANCER? ☐YES ☐NO

BOOKING INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PREFERRED START TIME: _____

FOLEY: ☐YES ☐ NO POSITION: _____ANESTHESIA TYPE: _____

RADIOLOGY: ☐X-RAY ☐C-ARM ☐NEW OEC C-ARM ☐FLUOROSCAN: ____ CERTIFIED: ☐YES ☐NO

EQUIPMENT: ☐CELL SAVER ☐ SCOPE ☐BRAIN LAB ☐ALOKA ☐ HAND TBL ☐CUSA ☐NEOPROBE

LASER: ☐GREEN LIGHT ☐HOLMIUM ☐ DIODE ☐KTP ☐YAG ☐ARGON BEAM ☐CAREWISE PROBE ☐BOOKWALTER ☐CYBERWAND ☐ULTRASOUND ☐SPY UNIT ☐OTHER: _____

BEDS: ☐SKYTRON (6500) ☐STERIS ☐BARIATRIC ☐MIDMARK ☐FRACTURE TABLE ☐JACKSON ☐MAYFIELD ☐BERCHTOLD

SPECIAL EQUIPMENT/SUPPLIES:_____

_____

INSTRUMENTATION/IMPLANTS: _____

REP NEEDED: ☐YES ☐NO

Cardiac

CARDIAC PROCEDURES: ☐PUMP ☐ PUMP STANDBY ☐ OFF PUMP EVH: _____ IMA: _____

RADIALS: ☐ LT ☐RT MAZE PROCEDURE: ☐YES ☐NO PROCTOR: _____

Neuro

CRANI/BRAIN LAB: ☐LEFT SIDE ☐RIGHT SIDE ☐FRONTAL ☐TEMPORAL ☐PARIETAL ☐OCCIPITAL

POSITION: ☐PRONE ☐LATERAL ☐SUPINE

SPECIAL EQUIPMENT / SUPPLIES_____

_____

CRANIOPLASTY / BONE FLAP REPLACEMENT: FROM: _____ NOTIFY MM &/OR AC: _____

Ortho

HIP NAILING: _____ANTEGRADE: ☐YES ☐NO RETROGRADE: ☐YES ☐NO TROCHANTERIC: ☐YES ☐NO

TIBIAL/HUMERAL FRACTURES: _____PROXIMAL: ☐YES ☐NO DISTAL: ☐YES ☐NO

POSITION/EQUIPMENT: _____ COMPANY: _____

OTHER: _____

_____

_____

_____

_____

_____

_____

CANCELLATION REASONS IF APPLICABLE

☐Abnormal Labs ☐Case Booked Elsewhere ☐Insurance Doesn't Pay ☐Patient Ate ☐Patient/Family Request/Refused

☐Physician Cancelled (Please Explain):_____

☐Other Cause (Please Explain):_____

Revised 6-3-2014