

**SURGERY SCHEDULING INFORMATION
PHONE: (972) 403-2756 Or (972) 403-2755
FAX: (972) 403-2856**

|  |  |  |
| --- | --- | --- |
| DATE OF REQUEST: |  |  |
|  |
| SURGERY DATE: |  | PREFERRED TIME/ORDER: |  |
|  |
| SURGEON: |  | ASSISTANT: |  |
|  |
| ANESTHESIOLOGY *OR* GROUP: |  |
|  |
| PATIENT LAST NAME: |  | FIRST: |  | MI: |  |
|  |
| SEX (CHECK): | MALE |  | FEMALE |  | PATIENT’S PHONE: |  |
|  |
| PATIENT’S DOB: |  | PATIENT’S SOCIAL SECURITY #: |  |
|  |
| PT. STATUS (CHECK): | DAY SURGERY |  | ADMIT |  | ESTIMATED LOS (Length of Stay): |  |
|  |
| PRE-TEST/REGISTRATION DATE AT HOSPITAL: |  | TIME: |  |
|  |
| ANESTHESIA TYPE (CHECK): | GENERAL |  | MAC |  | REGIONAL |  | OTHER |  |
|  |
| REQUESTED BY: |  |

ICD10 DIAGNOSIS CODE(S) *AND* DESCRIPTION:

CPT CODE(S) AND PROCEDURE DESCRIPTION:

|  |  |
| --- | --- |
| SPECIAL NEEDS: |  |
|  |
| EQUIPMENT (CHECK): | C-ARM |  | FLUOROSCAN |  | OTHER EQUIPMENT |  |
|  |
| AMOUNT OF TIME FOR PROCEDURE: |  |
|  |  |
| COMMENTS: |  |
|  |  |  |  |
| PRE-CERTIFICATION# |  | PRE-CERT PHONE# |  |
| **PLEASE SEND:****DEMOGRAPHICS, COPY OF DRIVERS LICENSE & INSURANCE CARD****6020 WEST PARKER ROAD ∙ PLANO, TEXAS 75093** |