

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

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| DATE OF REQUEST: | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SURGERY DATE: | | |  | | | | | | | | PREFERRED TIME/ORDER: | | | | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SURGEON: |  | | | | | | | | | | | | | | | | | | ASSISTANT: | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ANESTHESIOLOGY *OR* GROUP: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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:

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| 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** | | | | | | | | | | | | | |