

* REQUIRED INFO

PROCEDURAL SERVICES SCHEDULING FORM

***CASE DATE & TIME REQUESTED:**

PHONE: 763-3400 - PRESS "2"

FAX THIS FORM: 763-3191

***PATIENT NAME:** (Please Print Legibly)

***PT MRN:**

***PT DOB:**

SSN:

PT PHONE #

***SURGEON:**

***PROCEDURE:** OPEN LAPAROSCOPIC

***PROCEDURE LENGTH:**

DIAGNOSIS:

PRIMARY PHYSICIAN:

H & P BY:

***ADMISSION TYPE:** (CIRCLE ONE)

- OUTPATIENT
- 23 HOUR OVERNIGHT
- TBA
- ICU
- CURRENT INPT:

***ANESTHESIA TYPE:** (CIRCLE ONE)

- GENERAL
- CHOICE
- MAC (ANES. MONITORED)
- CONSCIOUS SEDATION (RN MONITORED)
- REGIONAL
- LOCAL
- NONE

ISOLATION

- MRSA
- VRE
- TB

LATEX ALLERGY

- YES
- NO

PACEMAKER/ICD/IMPLANTED DEVICES YES NO

MAKE/MODEL:

CARDIOLOGIST:

OPERATING ROOM INSTRUCTIONS

POSITIONING

- SUPINE
- PRONE
- LATERAL R L
- LITHOTOMY

OR TABLE

- REGULAR
- JACKSON: FLAT SPINE
- FRACTURE

VISUALIZATION/IMAGING

- C-ARM
- MICROSCOPE

SPECIAL MONITORING:

CELL SAVER: YES NO

INSTRUMENT AND IMPLANT SPECIAL REQUESTS:

WAS THE SALES REP NOTIFIED YES NO

FILLED OUT BY:

DATE: