



Surgery Scheduling Form
Phone: 903-408-1200 Fax: 903-408-1219

Patient Name: _____ Date of Surgery: _____ Time of Surgery: _____
Surgeon Name: _____ CPT Codes: _____
Procedure: _____
Pre-op Diagnosis: _____ ICD-10 codes: _____
Frozen Section Request [] Yes [] No Grafts/Tissue Request [] Yes [] No Procedure Length: _____
Grafts/Tissue Specifications: _____
Special Needs/Request: _____
Instrumentation to be Delivered/Vendor Name: _____

Patient Status: [] SDC [] IP

Labs: [] CBC (Z01.818) [] CXR (Z01.818) [] UA Pregnancy
[] BMP (Z01.818) [] UA (Z01.818) Other: _____ [] Antibiotic
[] PT/INR [] EKG (Z01.810) _____ [] VTE

Follow Surgical Antibiotic Prophylaxis for Adults Protocol []

[] Pre-op [] On Admission [] Type & Screen [] Pain Management per Anesthesia [] Beta Blocker

Allergies _____ Cardiac/Medical Clearance Obtained _____

Practitioner's Pre-op Appointment _____ Hospital Pre-op Request Date: _____

Practitioner's Signature

DATE

Patient Demographics

Gender [] M [] F Date of Birth: _____ Age: _____ Social Security # _____
Home Phone #: _____ Work Phone #: _____ Other #: _____
Date of Injury: _____ Insurance Name: _____
Insurance Phone #: _____ Precert/Authorization #: _____
Policy/Claim #: _____ Policy Holder: _____ Group #: _____
Policy Holder Employer: _____

Office Contact: _____ Date: _____

Office Phone#: _____ Office Fax #: _____

Surgery Scheduler Confirmed _____ Pre-op Confirmed _____

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