



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 Follow **SCIP Protocol** :

BMP (Z01.818) UA (Z01.818) Other: _____ Antibiotic

PT/INR EKG (Z01.810) _____ VTE

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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