Hunt Regional Medical Center

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** _____