Providence
Regional Medical Center
Everett

Surgery Scheduling Form

PATIENT INFORMATION

Patient Name ______________________ ☐ Male ☐ Female

Patient DOB ______________ MM/DD/YYYY

Patient Address ______________________

City ______________ State ______ Zip Code ______

Home Phone ______ Cell Phone ______ Work Phone ______

Insurance Name ______________ Insurance Auth Status ☐ Requested ☐ Complete

Insurance ID #: ______ 2nd Insurance #: ______ Auth #: ______

Subscriber Name: ______________________

Secondary Insurance: ______________________

PASC ☐ Peri Operative Surgical Home ☐

PROCEDURE INFORMATION

Procedure Date ______________ Procedure Start Time ______

Performing Physician ______________ Assist ______

Procedure Scheduled

Pre-Op Diagnosis ______________________

Anesthesia Type: ☐ Local Only ☐ General ☐ Spinal ☐ Pre Op Block ☐ RN Sedation

Admit Type: ☐ Outpatient Surgery ☐ Extended Hospital Outpatient ☐ Surgery Admit

Total Joint Fast Discharge: ☐ YES ☐ NO

Surgery Location: ☐ Colby Surgery ☐ ENDO/GI ☐ CVL ☐ L&D ☐ ASC

CPT Code ______________ ICD-10 Code ______________

ADDITIONAL INFORMATION – PLEASE FILL OUT COMPLETELY AND CHECK ALL THAT APPLY

☐ Interpreter needed Language ______________________

☐ Pacemaker/ICD Pacemaker Type ______ If checked, have orders been sent to Cardiologist? ☐ YES ☐ NO

☐ Frozen section ☐ Diabetes ☐ Sleep Apnea ☐ Latex Allergy

Special Equipment Requests

Form Originated by ______________ Scheduled by ______________

Scheduled Date ______________ MM/DD/YY

Reset Form Print Form

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