**SURGERY SCHEDULING REQUEST**

**NOTE: Fields in BOLD are required and must be complete prior to submission**

**Regional Scheduling: Phone (253) 573-7190 Fax (253) 426-6907**

(Last Revised: Jun 13, 2023)

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| --- | --- | --- | --- | --- |
| **Hospital:** | | | | |
| **Date of Surgery:** | | | **Start Time:** | |
| **Surgeon:** | | | Request Assist: Assist Name: | |
| **Patient Type:** In-Patient Out-Patient Extended Recovery (<24hrs) | | | Interpreter: Language**:** | |
| **PATIENT INFORMATION** | | | | |
| **Patient’s Last Name** | **First Name:** | Middle: | **Gender**:  Male  Female | Social Security Number**:** |
| **Date of Birth:** | **Primary Phone Number:**  Home Work Cell  Alternate Phone Number:  Home Work Cell | | Guarantor (if patient is a minor):  Guarantor Date of Birth: Gender: Male Relationship to Patient: Female | |

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| --- | --- | --- |
| **INSURANCE INFORMATION** | | |
| **Primary Insurance:** | | **Subscriber:** |
| **Subscriber ID#:** | **Authorization #:**  **No Authorization Required:**  **Authorization Pending: Reference Info:** | |

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| --- | --- |
| **DIAGNOSIS** | |
| **Diagnosis:** | **ICD 10:** |

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| **PROCEDURE LEFT RIGHT BILATERAL** | |
| **Name of Procedure:** | **CPT Code:**  **Procedure Length:** |
| **Open: Laparoscopic Arthroscopic: Robotic: Laser** Type: | |
| Comments/Specials/Implants: | |

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| **PATIENT FLOW (IN-PATIENTS ONLY)** |
| **Estimated Days of Admission at each Level of Care, Post Procedure:**  ICU Days: PCU Days: Med/Surg Days: |

|  |  |  |
| --- | --- | --- |
| **PRE-SCREEN** | | |
| **\*Phone: \*In-Person Visit: Already Scheduled:** | | |
| **Preferred Date 1:** | **Preferred Date 2:** | **Preferred Date 3:** |
| **Preferred Time Frame 1: AM PM** | **Preferred Time frame 2: AM PM** | **Preferred Time Frame 3: AM PM** |

AM (8:00 – 12:00) PM (12:00 PM – 4:00 PM) \*Determined by Completed Pre-Op Risk Screen