**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:  |

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| **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