Spectrum Health

Record SURGICAL PROCEDURE SCHEDULING REQUEST

AREA FOR HOSPITAL USE ONLY

Patient Name

DOB

MRN

Physician

CSN

NOTE: **INFORMATION WITH * MUST BE COMPLETE.**

***SCHEDULE PROCEDURE AT:**

- ☐ Big Rapids Hospital
- ☐ Blodgett Hospital
- ☐ Butterworth Hospital
- ☐ Gerber Memorial Hospital
- ☐ Grand Haven Center
- ☐ Helen DeVos Children's Hospital
- ☐ Kelsey Hospital
- ☐ Lake Drive Surgery Center
- ☐ Ludington Hospital
- ☐ Meijer Heart Center
- ☐ OB-Butterworth Hospital
- ☐ Pennock
- ☐ Reed City Hospital
- ☐ South Pavilion
- ☐ United Hospital
- ☐ Zeeland Community Hospital

Fax completed form to: 616.643.9290

***Requested Operating Room: Date and Time**	***Surgeon/Physician**	2nd Surgeon	☐ In block ☐ Out of block ☐ Group block _____

***Patient's (legal) name** Last	First	MI	***DOB**	***Age**	***Sex**

***Patient's address**	***City**	***State**	***Zip code**

***Patient's home phone**	Work phone	Cell phone

Next of kin, Legal guardian, Extended care facility, Other contact person	Phone	Relationship to patient

Type of insurance and policy number

Primary | Secondary

Facility/Physician authorization number

*Billing Special Needs: ☐ No special billing needs ☐ Specialty lens ☐ Fully cosmetic ☐ Partially cosmetic ☐ Other considerations _____

Patient needs interpreter: ☐ Yes ☐ No
Language requested _____

Patient diabetic? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ Insulin ☐ Oral ☐ Diet

Post acute services preference?
☐ Spectrum Health Continuing Care ☐ Other ☐ Unknown

Latex allergy? ☐ Yes ☐ No ☐ Unknown

History malignant hyperthermia? ☐ Yes ☐ No ☐ Unknown

Height | Weight

***Diagnosis (No abbreviations)**

ICD Code CM

***Procedure level** ☐ 1 ☐ 2 ☐ 3 ☐ 4 Comments _____

***Estimated procedure length**

_____
(incision to close SHH assigns turnover value)

***PROCEDURE TO BE PERFORMED (NO ABBREVIATIONS)**

***ANESTHESIA TYPE**

☐ Epidural ☐ Spinal ☐ Regional block ☐ Local ☐ General
☐ MAC ☐ Other _____

***ADMITTING STATUS** Office only instructions _____

☐ Outpatient ☐ Inpatient, Room number _____
☐ AM admit ☐ One day prior to surgery ☐ Bedded outpatient for recovery

Anesthesia pre/post block needs *(Submit Surgical Consent prior to day of service)*

☐ No block needed ☐ Epidural block ☐ Post-procedure block
☐ Transverse abdominis plane (TAP) block ☐ Block requested

Post-Procedure Destination ☐ Home ☐ Non-ICU ☐ Peds Non-ICU ☐ Peds ICU

Special Equipment/Instruments ☐ Ultrasound ☐ C-Arm ☐ Specimen imaging ☐ Laser _____
☐ Microscope ☐ Cyberwand ☐ Mini C-Arm ☐ Stealth ☐ O-Arm ☐ Cell saver ☐ Surgical table type _____

Implants specifics
Company Rep _____
Contact number _____

Additional equipment

Positioning details

TIME _____ **DATE** _____ Request submitted by (signature) _____

***Request submitted by (print)** _____ ***Contact phone** _____

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Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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