Record SURGICAL PROCEDURE SCHEDULING REQUEST

AREA FOR HOSPITAL USE ONLY

Patient Name
DOB
MRN
Physician
Last Four of SSN #

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

***SCHEDULE PROCEDURE AT:**

- ☐ **Dearborn Hospital**
- ☐ **Farmington Hills Hospital**
- ☐ **Grosse Pointe**
- ☐ **Macomb Surgery Center**
- ☐ **Royal Oak Hospital**
- ☐ **Taylor Hospital**
- ☐ **Trenton Hospital**
- ☐ **Trenton Surgery Center**
- ☐ **Troy Hospital**
- ☐ **Wayne Hospital**
- ☐ **West Bloomfield**

Fax completed form to: 947.522.4965

***Requested Operating Room: Date and Time** | ***Surgeon/Physician** | **Available Time** | 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 ☐ Cosmetic Time ______

Assisting: ☐ 1 PA ☐ 2 PA ☐ CSA ☐ Resident ☐ None

Latex allergy? ☐ Yes ☐ No ☐ Unknown
Nickel allergy? ☐ Yes ☐ No ☐ Unknown
History malignant hyperthermia? ☐ Yes ☐ No ☐ Unknown
BMI

***Diagnosis (No abbreviations)**

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

***Estimated procedure length** (incision to close CHE assigns turnover value)

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

CPT Code(s): | ☐ ERAS

***ANESTHESIA TYPE** ☐ Local with IV sedation ☐ LMA/Mask
☐ Epidural ☐ Spinal ☐ Regional block ☐ Local Only
☐ MAC ☐ Other ______ ☐ General ☐ No Anes.

***ADMITTING STATUS** ☐ Short Stay
☐ 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 ______
☐ IOM ☐ Navigation Information ☐ Table Motion

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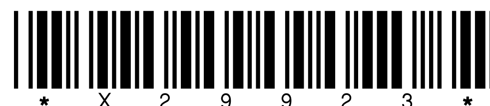
Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



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