

SURGERY SCHEDULING FORM

Fax# 818.902.5171 or email: Surgery.Scheduling@valleypres.org

Date of Surgery: _____ Requested Time (military): _____ Length(min): _____

Admit Status: OP(SDS) IP(Inpatient)

Patient Demographics Section

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____

Address: _____ City _____ State ____ Zip _____

Phone Number (Primary): _____ Alternate Phone: _____

Primary Language: English Spanish Other _____

Allergies: _____ HT _____ WT _____

Parent/Guardian/Facility Name: _____

Insurance /Authorization Section

Insurance Name (Primary) _____ Policy Number _____

Insurance Name (Secondary) _____ Policy Number _____

Insurance Type HMO PPO MediCare MediCal Worker Comp

If HMO IPA Name _____ Days Approved: _____

Authorization Number: _____ N/A Exp. Date _____

Primary Care Physician: _____ PCP Phone Number: _____

Workers Compensation Insurance Name: _____

Address: _____

Claim#: _____ Date of Injury _____

Adjusters Name: _____ Tel#: _____

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back)

Procedure/Consent/Equipment Section

Surgeon: _____

Request Assistant: Yes No _____

Contact Person Name _____ Tel# _____

Diagnosis:

ICD-10 _____ / _____ / _____ / _____ / _____

Procedure Type: Laparoscopic Laparotomy Anesthesia Type: _____

Procedure:

CPT Code _____ / _____ / _____ / _____ / _____

Area: Left Right Bilateral N/A **Position:** Supine Prone Lithotomy Lateral

Special Equipment (Implant/Hardware): None

C-ARM (Check box if required) How many C-ARM needed 1 2

Vendor /Company Name None _____

Rep Name _____ Tel# _____

Comorbidities: None Yes (check all that apply)

Cardiac Vascular Disease Hypertension Endocrine Diabetes Thyroid Disease

Respiratory Disease Smoker Sleep Apnea Kidney Disease Liver Disease

Neurologic Disease Hematologic Bleeding Disorders

Other _____

****All of the above fields are mandatory. ****

Pre-Op Test Results Section

Please fill out the areas below if known, to help process patients in a timely manner.

Pre-Op Testing Done at:

Name Physician: _____ Tel#: _____

UA Urine Preg (13<55) CBC BMP CMP PT/INR PTT Glucose Type & Screen

Type& Cross # _____ UNITS EKG CXR Other/Clearance: _____

Name of Specialist/Clearance: _____ Tel#: _____

Location of Testing: VPH Quest Other: _____

Additional Testing Ordered: (check all that apply) MRI CT U/S OB U/S Vascular Studies

Other _____

Thank you,

Surgical Services

Contact Number 818.902.5299