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)

VALLEY PRESBYTERIAN HOSPITAL

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