HackensackUMC
Mountainside

Surgical/Endoscopy Scheduling Request Form

FAX TO O.R. SCHEDULING: 973-680-7946 **REVISED ON:_____________**

Confirmation#____________

DOS:____________ Procedure Time:__________ **Scheduler's Name:_________**

Physician:__________________________ **Assistant:________________________**

Patient Name:____
Last First MI

DOB:__________________ **Sex:_____** **SS #____________________**

Address:____
Street Apt. #
____ __________ Phone:(Home)___________
City State Zip Phone:(Cell)____________

Admission Type: SDS___ EAM___OPR(23Hr)____

Procedure:____

Procedure Code(s): _____________ Diagnosis Code(s): __________________
Requested Case Length:____________ **Right____Left____Bilateral____**

Anesthesia Type: General ___ MAC /IVCS____Local ___Spinal ___Epi ___Block (Specify) __________

Pre Admission Testing Date:___________ Time:_______

Physician Signature:

Pre Admission Tests Ordered: (Please Circle)

1- Urinalysis	13- PSA	37- No PAT 's Required
2- CBC/DIF	14- Type & Screen	38- PAT's Done Off Site
3- CCA-18	15- Type & Crossmatch	39- Pull Old Chart
4- Lytes	16- Autologous	40- PAT's to be faxed
5- Lytes Plus	20- C&S	42- Cell Saver
6- PT	21- EKG	43- INR
7- PTT	22- Chest X-Ray	44- Blood levels-seizure meds
8- ESR	25- Incentive Spirometry	45- H&H
9- CEA	30- Liver Function	54-COSMETIC SURGERY
10- CA-125	32- PCA	55-PACEMAKER/AICD
11- Serum Beta HCG	33- Other	56-LATEX ALLERGY
12- RPR (VDRL)	36- Stat Day Of Surgery	57-Bariatric PAT Protocol

NEEDS INTERPRETER?
___________ Signing
___________ Language

Comments/Special Requests:____

Insurance Information : ____
FAX PAT RESULTS TO PRIMARY:__________________________FAX #(___)_________________
H&P TO BE PROVIDED BY:______________________Office phone #(___)____________________

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