***Please note an incomplete form will not be processed

Surgery Scheduling Order Form

Please print legibly

Fax to OR scheduler: (415)750-4850

OR Scheduler email: smmc-sf-or@dignityhealth.org

Questions: (415)750-5772

PSA Scheduling (M-F, 9am-3:30pm): (415)750-4900

Date of request__________ Requestor Name________________

Phone_________________ Fax___________________________

Pt. (legal) Last Name: ____________________________________

Pt. (legal) First Name: ___________________________ M.I.

Date of Birth: _________________________ Sex: M F

Primary Language:_______________________________________

Interpreter needed: Y N

H&P completed by: Surgeon Primary Care **Delivery Method**: Day of Surgery Surgeon will fax Dictate to SMMC

Primary Care Physician:_____________________________ Primary Care Physician Phone:_________________________ No PCP

Surgery request date/time____

Surgeon___________________________ Assistant__________________________ Estimated procedure duration_______________

Pt. home phone #:______________________ Pt. cell #:______________________ Pt. work #: _______________________

Patient's Address:____

Street Address, City, State, and Zip Code

Patient special needs:____

Diagnosis:____

Date of Admission (if different from surgery date):__________________________________

MD office to send copy of patient insurance card: Yes No

ICD10 code:___________________________ CPT codes:_____________________________

Insurance Name:_______________________ ID#:__________________________Group #:_________________________

Secondary Ins. Name:___________________ Subscriber Name:________________ DOB:_________________________

Insurance Authorization obtained: Yes No Authorization#:_________________________ Self-Pay: Yes No

Special Requests / Instrumentation:

Robot Implants/vendor Vendor notified/comments:______________________

C-arm Hana Table Cellsaver X-ray Node Seeker

Laser Microscope Allograft/type Ultrasound Pathology Flouroscan

Hardware needs:___________________________ Other:_________________________

Positioning for surgery____

Pathologist needed at time of surgery Radiologist needed at time of surgery

Anesthesia Type:

General Local

Regional MAC

Block/post op pain management

Other:

Pacemaker

Company:___________________

PHYSICIAN ORDERS **Legal admission status for billing:** Inpatient Outpatient Latex allergy

Surgical Consent for (do not abbreviate and include laterality)

____

____

PREOPERATIVE ORDERS Specific surgeon request____

TEDS Knee Thigh Sequential venous compression device Pharmacological DVT prophylaxis

Pre-op antibiotic (see dosage guidelines)_________________________________ Other:_____________________________

LABS/X-RAYS PT PTT UA Chem 8 Chem 14 CBC Chest x-ray EKG Anesthesia guidelines Other____________

BLOOD PRODUCTS Type & screen Type & Cross ____ units Autologous blood ____ units donated Other ____________

____________ ____ ______________

Date Physician signature per Title 22, §70717 (c and i) and §70751 (g) SMMC ID#

Rev. 10/31/2016