Information must be faxed / received by the procedural department and admitting no later than 72 hours prior to the procedure.

Admitting Fax: 432-582-8801 Surgery Fax: 432-582-8802

Surgery Reservation for:

Dr._____ Assistant_____

Patient Legal Name _____ Age_____ DOB _____
First Initial Last

Address _____
Street City State ZIP

Phone #_____ W_____ C_____ Other_____

SS #_____ Gender ❑M ❑ F Latex Allergy: ❑Yes ❑No Weight _____ BMI_____

❑Post Op Admission ❑Outpatient ❑ Inpatient/ Room #_____ Day before Adm._____

Procedure _____

_____

_____

Pre-Op Diagnosis _____

Surgery/Procedure Date_____ Start Time _____ Time Required _____

Date Faxed_____ ICD-10 Code***_____ CPT Code*** _____ ***Required

Implants Type _____ Brand _____

Vendor Name _____ Contact #_____

Special Instruments:_____

Special Equipment: ❑CArm ❑Cell Saver Other_____

Anesthesia: ❑Local ❑Moderate Sedation ❑MAC ❑General ❑Spinal/Regional

Anesthesia Group (if indicated)_____ Special Request _____

Physician Signature: _____ Date: _____ Time: _____

Insurance Information - Person Financially Responsible

Name of Insured _____ Insured S/S #_____

Relationship to Patient _____ DOB _____

Copies of patient insurance cards (Front & Back) OR complete information below ***Required

Primary Insurance_____ Policy #_____ Group # _____

Primary Insurance Phone # _____

Secondary Insurance _____ Policy #_____ Group #_____

Secondary Insurance Phone # _____

Authorization & Pre-Certification # _____ Expiration Date_____

Self Pay ❑Yes ❑No

ICA Claim ❑Yes ❑No Date of Injury_____ ICA Carrier_____

ICA Carrier Address _____ Phone_____

Required Patient Data to be Faxed with Scheduling Form 72 HOURS BEFORE DAY OF SURGERY

1. Surgeon's Orders Faxed with Reservation: ❑Yes ❑No ❑To Follow
2. Surgical PreOps to be done at facility: ❑Yes ❑No If No, where? _____
3. Clearance (if needed): ❑Medical ❑Cardiac ❑Pulmonary Dr. Name:_____
4. History & Physical Attached: ❑Yes ❑No ❑Will be done day of surgery
5. Completed Informed Consent Attached: ❑Yes ❑No ❑Will be done day of surgery

Account Number:	MR Number:
Patient Name:	
Admit Date:	

DOB	Age	Sex	HT	WT	RM-BD	PT	Svc	FC

Allergies:

Attending Physician Name:

ORMC
Odessa Regional Medical Center
520 East 6th Street
Odessa, Texas 79761
(432) 582-8000

SURGERY/PROCEDURE SCHEDULING/PHYSICIAN ORDER 117-883 12/2013 Rev. 09-2015