NOT PART OF THE MEDICAL RECORD

SURGERY/PROCEDURE SCHEDULING FORM

Information must be faxed / received by the procedural department and admitting no later than 72 hours prior to the procedure. Admitting Fax: 801-350-8242 Surgery Fax: 801-350-4406

Surgery Reservation for:
Dr._____ Assistant_____

Patient Legal Name_____ Age_____ DOB_____
First Initial Last

Address_____
Street City State ZIP

Phone H_____ W_____ C_____ Other_____
SS#_____ Gender: ❑M ❑F Latex Allergy: ❑Yes ❑No Weight_____
❑Post Op Admission ❑Outpatient ❑Inpatient/ Room # _____ Day before Adm._____

Procedure_____

_____

_____

Pre-Op Diagnosis_____
Surgery/Procedure Date_____ Start Time_____ Time Required_____
Date Faxed_____ ICD-9 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_____

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:	

Salt Lake Regional MEDICAL CENTER
1050 East South Temple – Salt Lake City – Utah 84102
(801) 350-4111

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies:

Attending Physician Name: