

**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: 801-562-4287 Surgery Fax: 801-562-4288

Surgery Reservation for:

Dr. _____ Assistant _____

Patient Legal Name _____ Age _____ DOB _____
First Initial LastAddress _____
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 NoICA 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: _____

Jordan Valley
MEDICAL CENTER
3580 West 9000 South
West Jordan, UT 84088
(801) 561-8888

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies: _____

Attending Physician Name: _____