(Patient Label)

BOYS TOWN National Research Hospital®

SURGERY SCHEDULING FORM

Surgery date: _____ **Surgery time:** _____ **Surgeon:** _____

Office phone number: _____ **Office contact person**: _____ **BT Scheduler**: _____

Patient Name: _____ **DOB:** _____ ☐ **Male** ☐ **Female**

Address: _____

Parents/Legal Guardian: _____ **Relationship to patient:** _____

Phone numbers: Home: _____ **Work:** _____ **Cell:** _____

Diagnosis: _____

_____

Procedure: _____

_____

Type of Anesthesia _____ **Length of case**: _____

☐ **EAST** ☐ **WEST** **Date of last office visit:** _____

Imaging needs: ☐ X-ray ☐ dental X-rays ☐ fluoroscopy (C-arm) ☐ mini C-arm ☐ Ultrasound

Equipment needs: ☐ NIM _____ ☐ laser _____ ☐ implant _____ ☐ other _____

☐ Platelet Rich Plasma (PRP) Therapy

Preferred language for healthcare: _____ **Interpreter (including sign) needed:** ☐ **Yes** ☐ **No**

History & Physical to be completed by: ☐ **Surgeon** ☐ **PCP - Name:** _____ **Phone:** _____

Admission type: ☐ **Outpatient** ☐ **Inpatient (pre-authorization required) Authorization #**_____

Specific patient, procedure or treatment needs: _____

_____

☐ **KUB needed (for Urology Cases only)** ☐ **U/S, X-Ray reports - Where were tests done?** _____

Insurance Coverage (please fax copy of card):

_____

Employer: _____ **Policy Holder:** _____

Policy #_____ **Group #**_____ **Benefits & Eligibility Phone #**_____

☐ **Provided sufficient information so that patient and/or guardian understand:**

- The nature of his/her condition
- The purpose of the proposed procedure or treatment
- The risks, benefits, consequences and the probability of success of the proposed procedure or treatment
- The alternatives
- The prognosis if the procedure is not performed or any treatment given

Initiate orders per my pre-op preferences/orders
Initiate anesthesia protocol

_____ _____ _____

Physician Signature **Date** **Time**

EMAIL COMPLETED SHEET TO surgery.scheduling@boystown.org or FAX: 402-758-7778 QUESTIONS, CALL: 402-758-7777