Tri-State Memorial Hospital & Medical Campus

SURGERY SCHEDULING FORM

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____ **Phone Number(s):** _____

Guarantor: _____ **Phone Number:** _____

Best Time to Call for Pre-Op Appointment: _____

Procedure/Surgery Date: _____ **Time:** _____ **Confirmed with Scheduler?**

☐ **Yes** ☐ **No**

Description: _____

_____

Additional Information (Equipment): _____

Was vendor notified? ☐ **Yes** ☐ **No** **Contact Name:** _____ **Phone:** _____

Does patient have history of MDRO/VRE? ☐ **Yes** ☐ **No**

☐ **Inpatient** ☐ **Outpatient*** *Extended Recovery is OUTPATIENT status – Patient may stay up to 23 hours.

☐ **Post/Follow Up Appointment** **Date:** _____ **Time:** _____

Procedure Code(s): _____ **Diagnosis Code(s):** _____

Attending Physician(s): _____ **Assistant (if available):** _____

Primary Care Physician: _____

Insurance: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **Relationship:** _____

Insurance Phone: _____

Has prior authorization been obtained? ☐ **Yes** ☐ **No** **Date Received:** _____

Authorization #: _____ **Number of Days Approved:** _____

Contact Person at Insurance Company: _____

Please include Surgery Scheduling Form along with:

Surgical Consent • **Sterilization Consent *(if applicable)*** • **Admitting Orders** • **Copy of Insurance Card**

Tri-State Memorial Hospital Surgery Scheduling

Fax: (509)751-4568 **Phone: (509) 758-4661**