



SSF

NMC Health Surgery Scheduling Information

1) Demographics	
SSN	
Name	
DOB	
Biological Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Address	

2) Patient Contact					
Primary #1	H/C/W	Phone #2	H/C/W	Phone #3	H/C/W
#		#		#	
Individual name:		Individual name:		Individual name:	
Relationship: <input type="checkbox"/> Self (pt) <input type="checkbox"/> Nursing Home Staff <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		Relationship: <input type="checkbox"/> Self (pt) <input type="checkbox"/> Nursing Home Staff <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		Relationship: <input type="checkbox"/> Self (pt) <input type="checkbox"/> Nursing Home Staff <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Significant Other <input type="checkbox"/> Other	

3) Health & Procedure		Height	Weight	BMI
Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Insulin <input type="checkbox"/> Non-Insulin	Medical Clearance Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Clearance Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood Transfusion: <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	Preop COVID-19 Testing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Surgeon:	Consented Procedure:			
Date of Procedure:				
Registration Type: <input type="checkbox"/> Outpatient/ SDC <input type="checkbox"/> Outpatient/ SDC w/ Bed <input type="checkbox"/> Inpatient	Edit Scheduling: <input type="checkbox"/> Place on Hold <input type="checkbox"/> Reschedule Date <input type="checkbox"/> Cancel	Reschedule Date:	Scheduling Requests: Requested Time _____ <input type="checkbox"/> Move Up <input type="checkbox"/> Move Down <input type="checkbox"/> Don't Move Estimated Case length:	
Requested Staff: <input type="checkbox"/> CRNA (Anesthesia) <input type="checkbox"/> RN Monitor (x2 RNs) / <input type="checkbox"/> Moderate Sedation (non-anesthesia provider with x2RN) <input type="checkbox"/> Local (only x1 RN) <input type="checkbox"/> First Assist _____ <input type="checkbox"/> Pathologist (Frozen/Fresh Specimen)		Specialty Equipment/Sets Needed:		
Patient Positioning: <input type="checkbox"/> Supine <input type="checkbox"/> Lateral <input type="checkbox"/> Prone <input type="checkbox"/> Beach Chair <input type="checkbox"/> Lithotomy <input type="checkbox"/> Other:		Implant/Graft Type Needed:		
Vendor Company:	Date/Time Rep Notified:	Assisting Surgeon:		
Vendor Personnel:				

4) Registration Insurance			
CPT Code	ICD 10 Code		
Pre-op Diagnosis			
Primary Insurance Company			
Prior Auth required	<input type="checkbox"/> Yes <input type="checkbox"/> No	Auth #	Date Range:
Verified by (Insurance Rep)	Contact #		

Printed Name of person completing _____ Date _____