LAS COLINAS Medical Center

# Surgery Schedule Request Form

***Phone 972.612.6565***

**Fax to 469.484.1311**

Date: ____________

Time in: ____________

BY: ____________

*Las Colinas Internal use ONLY*

PATIENT'S NAME ____________ PATIENT'S DOB ____________

PATIENT'S SOCIAL SECURITY # ____________ PATIENT'S DAYTIME PHONE # ____________

PATIENT'S ADDRESS ____________ ☐ MALE ☐ FEMALE

PATIENT'S CITY ____________ PATIENT'S STATE ____________ PATIENT'S ZIP ____________

NAME of INSURANCE COMPANY ____________ PATIENT'S ALTERNATE PHONE # ____________

ID # for INSURANCE COMPANY ____________ CONTACT NUMBER of INSURANCE COMPANY ____________

INSURED'S NAME/RELATION TO PATIENT ____________ Group ID # (Include Insurance Demographics) ____________

Admission Type: ☐ AM ADMIT ☐ DAY SURGERY ☐ 23 HOUR OBSERVATION

Date of Surgery : ____________ Time of Surgery: ____________

Length of Surgery: ____________

Surgeon's Name: ____________

Surgeon's Phone #: ____________ Fax #: ____________

Type of Anesthesia: (circle one) General Local Regional IV Sedation MAC Cardiac

Other: ____________

PROCEDURE:

Isolation Status? YES NO (circle one)

Does patient have Allergy to Latex? YES NO (circle one)

Is patient over 400 pounds? YES NO (circle one)

Using(circle one): JACKSON TABLE WILSON FRAME IMAGE CELL SAVER HANA HOLMIUM LASER CO2 LASER

Circle one: OPEN LAPAROSCOPIC C-ARM NEUROMONITORING MICROSCOPE MINIMALLY INVASIVE

IMPLANTS: ____________ VENDORS: ____________

Needs: ____________

Position: ☐ Supine ☐ Prone ☐ Lateral ☐ Lithotomy ☐ ____________

Office will order: ____________ From: ____________

Diagnosis: ____________

**Request by:** ____________

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