LAS COLINAS Medical Center

Surgery Schedule Request
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 # ____________

☐ MALE ☐ FEMALE

PATIENT'S ADDRESS ____________

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 ____________

NAME of INSURED ____________ Group ID # (Include Insurance Demographics) ____________

Admission Type: ☐ AM ADMIT ☐ DAY SURGERY

Date of Surgery : ____________ Time of Surgery: ____________

Length of Surgery: ____________

Surgeon's Name: ____________

Surgeon's Phone #: ____________ Fax #: ____________

Type of Anesthesia: (circle one) General Local Regional

Other: ____________

PROCEDURE:

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

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

Using(circle one): HOLMIUM LASER CO2 LASER IMAGE CELL SAVER

Circle one: OPEN LAPAROSCOPIC MINIMALLY INVASIVE

Other: ____________

Needs: ____________

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

Office will order: ____________ From: ____________

Diagnosis: ____________

Request by: ____________

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