



HOUSTON HEALTHCARE

# Surgery Scheduling Form

Date: \_\_\_\_\_ Pages (including cover): \_\_\_\_\_

Time: \_\_\_\_\_ From: \_\_\_\_\_

## SCHEDULING & REGISTRATION

To schedule patient, please fill out this area, mark box for appropriate facility and fax this form to:

HASC LLC (WR)

Fax: (478) 329-3454

Phone: (478) 329-3118

HHC (WR) O.R.

Fax: (478) 542-7887

Phone: (478) 542-7836

HHC (WR) Endo.

Fax: (478) 322-4886

Phone: (478) 542-7715

HHC (Perry) O.R.

Fax: (478) 218-1748

Phone: (478) 218-1746

Patient's Name: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Date(s) of Service: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Anesthesia Type: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Procedure(s): \_\_\_\_\_

Rep / Equipment: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_ CPT Code: \_\_\_\_\_

Medicare Inpatient Only procedure?  Yes  No

Insurance carrier: \_\_\_\_\_

Precert #: \_\_\_\_\_  Inpatient  Outpatient  Observation

## PRE-OP

To schedule pre-op, please call the appropriate facility below:

HASC LLC (WR)

(478) 329-3118

HHC (WR) O.R.

(478) 542-7925

HHC (Perry) O.R.

(478) 218-1746

Prior to patient's day of admission, please fill out this area below and fax with required records to the appropriate facility below:

HASC LLC (WR)

Fax: (478) 329-3454

HHC (WR) O.R.

Fax: (478) 975-6908

HHC (WR) Endo.

Fax: (478) 322-4886

HHC (Perry) O.R.

Fax: (478) 218-1748

Pre-admit Time: \_\_\_\_\_

Records reminder list below. (Please check all that apply to this patient/procedure.)

MD Orders \*REQUIRED\*

History & Physical \*REQUIRED\*

Informed Consent(s) \*REQUIRED\*

Medicaid Sterilization Consent - if applicable - required.

Clearance Letter (Circle: Y / N , and list Type: \_\_\_\_\_)

Lab

EKG Results

Chest X-ray reports

Medication List - Including medication name(s) and dosage