SURGERY SCHEDULING FORM

Fax# 818.902.5171 or email: Surgery.Scheduling@valleypres.org

Date of Surgery: 2024-01-28 Requested Time (military): 1200 Length(min): 500

Admit Status: ☐OP(SDS) ☑IP(Inpatient)

Patient Demographics Section

Last Name: Perchant First Name: WIGGINS

Date of Birth: 1989-06-04 Gender: ☑ Male ☐ Female Field : Vascular

Address: _____ City _____ State ____ Zip _____

Phone Number (Primary): _____ Alternate Phone: _____

Primary Language: ☑ English ☐ Spanish ☐ Other _____

Allergies: None HT _____ WT _____

Parent/Guardian/Facility Name: _____

Insurance /Authorization Section

Insurance Name (Primary) _____ Policy Number _____

Insurance Name (Secondary) _____ Policy Number _____

Insurance Type ☐HMO ☐PPO ☐MediCare ☐MediCal ☐Worker Comp

If **HMO IPA** Name _____ **Days Approved**: _____

Authorization Number: _____ ☐N/A Exp. Date _____

Primary Care Physician: Saul Goodman PCP Phone Number: _____

Workers Compensation Insurance Name: _____

Address: _____

Claim#: _____ Date of Injury _____

Adjusters Name: _____ Tel#: _____

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back)

Procedure/Consent/Equipment Section

Surgeon: DrStrange

Request Assistant: ☑ Yes ☐ No

Contact Person Name _____ Tel#_____

Diagnosis:

Patient experienced severe coughs and is on the verge of lung collapse.

ICD-10 69 / _____ / _____ / _____ / _____

Procedure Type: ☑Laparoscopic ☐Laparotomy Anesthesia Type: type1anesthesia?

Procedure:

AV fistula

CPT Code 420 /_____ / _____ / _____ / _____

Area: ☑Left ☐Right ☐Bilateral ☐N/A **Position:** ☐Supine ☐Prone ☐Lithotomy ☐Lateral

Special Equipment (Implant/Hardware): ☐ None

tweezers, knife, needles, threads

☐ C-ARM (Check box if required) How many C-ARM needed ☐ 1 ☐ 2

Vendor /Company Name ☐None _____

Rep Name _____ Tel#_____

Comorbidities: ☐None ☑Yes (check all that apply)

☐Cardiac ☑Vascular Disease ☐Hypertension ☐Endocrine ☐Diabetes ☐Thyroid Disease

☐Respiratory Disease ☑Smoker ☑Sleep Apnea ☐Kidney Disease ☐Liver Disease

☐Neurologic Disease ☐Hematologic ☐Bleeding Disorders

☐Other _____

****All of the above fields are mandatory. ****

Pre-Op Test Results Section

Please fill out the areas below if known, to help process patients in a timely manner.

Pre-Op Testing Done at:

Name Physician: _____Tel#: _____

☐UA ☐Urine Preg (13<55) ☐CBC ☐BMP ☐CMP ☐PT/INR ☐PTT ☐Glucose ☐Type & Screen

☐Type& Cross #_____ UNITS ☐EKG ☐CXR ☐Other/Clearance: _____

Name of Specialist/Clearance: _____ Tel#: _____

Location of Testing: ☐ VPH ☐ Quest ☐ Other: _____

Additional Testing Ordered: (check all that apply) ☐ MRI ☐CT ☐U/S ☐OB U/S ☐Vascular Studies

☐ Other _____

Thank you,

Surgical Services

Contact Number 818.902.5299