Please write or type clearly

Valley Regional Hospital OR Booking Worksheets

Please fax booking sheets to 603 542-1892 (OR)

Patient Name: _____ **Date of Birth:** _____
Last name First name MI

Address: _____ **Insurance:** _____

_____ **Insurance No.** _____

Pre-certification No. _____

Home Phone: _____ **Work Phone:** _____

Other contact no.: _____ **Contact Person:** _____

Surgeon: _____ **Assistant:** _____

Surgery Date: _____ **Surgery Time:** _____ **Estimated Duration:** _____

Diagnosis: _____

Procedure: _____

_____

Special Equipment Needs: (C-Arm, Pathology, Implants, etc.)

_____

_____

Medical Dr./PCP _____ **History and Physical: by** _____

Diagnostic Test(s) i.e. Lab/X-rays/EKG/Stress Tests/etc already performed.

Where performed: _____ **Date performed:** _____

Location of X-rays if needed: _____

Status Form: Full Admit (Acute) _____ Ambulatory Surgery (SDS) _____ Procedure Room (Local) _____

PAT Date: _____ **Time:** _____ **Phone: Y / N**

For doctor's office use:

Please fax *completed* paperwork to SDS 542-7848 within 48 hours of surgery

Preop Checklist

History and Physical	____	Date Completed _____	Faxed ___
Consent Signed	____	Date Completed _____	Faxed ___
Status Form	____	Date Completed _____	Faxed ___
Preop Orders	____	Date Completed _____	Faxed ___
Medicaid Forms	____	Date Completed _____	
Preauthorization	____	Date Completed _____	

PCP Preauthorization for Post-op Pain Control _____

Please remember that all consents need to be signed (by surgeon, patient and witness), dated and timed.
Status forms and preop orders need to be signed, dated, and timed. If you are unsure of a time for admittence, please leave it blank and we will fill in the time of arrival. *Thank you.*