Alice Peck Day Memorial Hospital

OR and Procedure Room Booking Sheet

Surgical Scheduler Tel: 603-443-9514 Fax: 603-448-7476

☐ *New* ☐ *Rescheduled* ☐ *Cancelled*

Patient Name: _____ DOB: _____ Age: _____ Male/Female Weight ____

Address: _____ Phone Numbers: Home: _____

Cell: _____

Work: _____

Previous Patient at A.P.D.? Yes No Social Security No: _____

Procedural Information

Surgeon: _____ Assistant(s): _____

Primary Care Providor: _____ Phone: _____

Diagnosis: _____

Procedure: _____

ICD9 code(s): _____ CPT code(s): _____ Length of procedure: _____

DATE OF PROCEDURE/SURGERY: _____ Case Order: 1 2 3 4 5 no pref

ANESTHESIA TYPE:

☐General ☐Regional ☐Spinal ☐ Epidural ☐Local ☐MAC ☐ Conscious Sed ☐Choice

ADMISSION TYPE: ☐**SDS** ☐**SDS/ (23 hr stay)** ☐**Full Admit** ☐ **Inpatient**

LOCATION: ☐**Operating Room** ☐**Procedure Room** ☐**ICC** ☐**Radiology**

Equipment needs:

PATIENT PREPARATION INFORMATION

Medical Problems: None Diabetes HTN CAD CVD CHF PVD Sleep Apnea COPD Obesity Heart Valve disease Renal Insufficiency Asthma Arrhythmias Neuro/Muscle Dis Age over 50 Other: _____ **Latex Allergy** Yes No

History and Physical To be completed by: _____

Date of H&Pappt: _____ H&P Providor's Phone Number: _____

Consults:

Pre Op **Medical Consult** No Yes/date _____ **Anesthesia Consult** No Yes/date _____

Provider: _____ **Provider:** _____

☐Physical Therapy : pre op Yes No ☐Occupational Therapy ☐Social Services

PATIENT FINANCIAL INFORMATION

Primary Insurance _____ ID#: _____

Address _____ Group Number _____

Phone Number: _____ Subscriber: _____

Secondary Insurance: _____ Number: _____

Workman's Comp Ins: _____ Address: _____

Phone: _____ Date of Injury: _____