PAIN MANAGEMENT SURGICAL BOOKING FORM

Please fax all bookings with a current HIPAA, relevant notes & diagnostic testing to 201-537-6894 or email to bookings@lynxmm.com. Thank you!

PATIENT INFORMATION

Name: txt_name|patientfullname	DOB: txt_dob|DOI	Age: txt_age	txt_sex|S	SSN: txt_ssn|SSN
Street Address: txt_address|Address1		City: txt_city|City		State: txt_sta Zip: txt_zip|Zi
Home #: txt_Phone2|Phone	Cell #: txt_mob|Phone2	E-Mail: txt_eMail|eMail		Language:
Emergency Contact (Name & Relationship):				Phone #:
Primary Physician Name:				Phone #:

INSURANCE INFORMATION (Insurance card must accompany scheduling form (front & back))

Primary Ins Name: txt_InsCo|InsCo		Phone: txt_InsPhone|InsPh	Policy #: txt_policy_no|polic
Subscriber Name:	DOB:	Relationship to Pt: ☐Self ☐Spouse ☐Parent ☐Other: _____	
Worker's Comp: Yes ☐ No ☐ ***PLEASE ATTACH*** No Fault: Yes ☐ No ☐ ***AUTH LETTER***	WCB#: txt_WCBG	Case Claim #: txt_ClaimNum	Phone #:
Is This A Lien: Yes ☐ No ☐ ***PLEASE ATTACH SIGNED LIEN***	Attorney Name: txt_attorney|Attorney		Phone #: txt_attorneyPhno|
Adjuster: txtAdjuster|AdjUserI	Auth #:	Date of Auth:	DOA/DOI: **txt_doa|DOA**

SURGICAL PROCEDURE INFORMATION

Surgeon:	Assisting Surgeon:	Date Request #1: **txt_date|To** #2: _____

☐ ESI: Level: _____ Side: _____	☐ Cervical (62310) ☐ Thoracic (62310) ☐ Lumbar (62311) ☐ Caudal (62311)	☐ MBB ☐ Facet Level: _____ Side: _____	☐ Cervical(64490) ☐ Thoracic (64490) ☐ Lumbar (64493)	☐ Diagnostic ☐ Confirmatory
☐ TFESI: Level: _____ Side: _____	☐ Cervical (64479) ☐ Thoracic (64479) ☐ Lumbar (64483)	☐ RF: Level: _____ Side: _____	☐ Cervical (64633) ☐ Thoracic (64633) ☐ Lumbar (64493) ☐ Sacroiliac (64635) ☐ Other: _____	
☐ Discogram: Level: _____ Side: _____	☐ Cervical (62291) ☐ Thoracic (62291) ☐ Lumbar (62290)	☐ Discectomy Level: _____ Side: _____	☐ Cervical (63020) ☐ Thoracic (63020) ☐ Lumbar (63030)	
☐ SCS Trial ☐ SCS Perm Level: _____ Side: _____	☐ Cervical (62291) ☐ Lumbar (62290)	☐ Sympathetic Nerve Block Level: _____ Side: _____	☐ Stellate Ganglion Block (64510) ☐ Lumbar (64520)	
☐ TPI (20552 / 20553) Location(s):			☐ Sacroiliac Joint Injection (27069)	
☐ BMAC (0263T) Location(s):			Side:	

☐ Other: _____

DIAGNOSIS

☐ Cervical Pain (M54.2) ☐ Mid Back Pain (M54.6) ☐ Radiculopathy (☐Cervical(M54.12) ☐Lumbar(M54.16) ☐Thoracic(M54.14)
☐ Low Back Pain (M54.5) ☐ Sciatica (M54.3) ☐ Spondylolysis (☐Cervical(M43.02) ☐Lumbar(M43.06) ☐Thoracic(M43.04)
☐ Herniated NP (M51.9) ☐ CRPS (G90.50) ☐ Facet Syndrome (M54.08) ☐ Other:

_____

SPECIAL REQUESTS

Equipment/Vendor:	Supplies:
Instrumentation:	Other:

PREOPERATIVE MEDICAL CLEARANCE

SCS Trial/Perm & Discectomy Patients require: H&P, EKG, Chest X-Ray, Blood Work (CBC w/ iff, CMP, PT/PTT) & Clean Catch UA
Clearing Physician/Clinic: _____ Phone: _____

SURGICAL SCHEDULER'S INFORMATION

Name:		Office/Clinic:
Phone:	E-Mail:	Booked By:

Surgeon Signature: _____ Date: txt_date\|ToDay Reviewed By: _____

Patient Information

Personal Information			
First Name	txt_fname|FirstName	**Middle Name**	txt_mname|MiddleName
Last Name	txt_lname|LastName	**D.O.B**	txt_dob|DOB
Gender	txt_sex|Sex	**Address**	txt_address|Address1
City	txt_city|City	**State**	txt_state|State
Cell Phone #	txt_mob|Phone2	**Home Phone**	txt_Phone2|Phone
Work	txt_work_phone|work_phone	**Zip**	txt_zip|Zip
Email	txt_eMail|eMail	**Extn.**	Text12
Attorney	**txt_attorney|Attorney**	**Case Type**	txt_casetype
Attorney Address	txt_attorneyAdd|AttorneyAdd	**Attorney Phone**	**txt_attorneyPhno|Attorney**
Case Status		**SSN**	txt_ssn|SSN

Insurance Information			
Policy Holder	txt_name123|patientfullname	**Name**	txt_InsCo|InsCo
Address	txt_Insaddress987|InsAddres	**City**	txt_Inscity|InsCity
State	txt_Insstate987|InsState	**Zip**	txt_Inszip|Inszip
Phone	txt_InsPhone987|InsPhone	**Fax**	
Contact Person		**Claim File #**	**txt_ClaimNumber|ClaimNu**
Policy #	txt_policy_no|policy_no	**WCB Group**	txt_WCBGroup|WCBGroup

Accident Information			
Accident Date	txt_doa|DOA	**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission	txt_doe12|LASTDOE	**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information			
Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information			
Name	txtAdjusterlAdiUserName	**Phone**	txtAdjusterph|AdjPhone
Extension		**Fax**	
Email			