UCI Health

Confirm#

Account#

Clear Form

Print

Surgery Scheduling Request Form

First Fax: (562) 493-5742 Then Call to Schedule (562) 799-3566 0900-1700

*PATIENT LEGAL ID NAME (LAST): (FIRST):

DATE OF BIRTH: AGE: SEX: M F PRIMARY LANGUAGE:

PRIMARY PHONE#: 2ND PHONE#: BEST TIME TO CALL:

ADDRESS:

CITY: STATE: ZIP CODE:

SOCIAL SECURITY #: PT FROM HOME SKILLED NURSING

INSURANCE NAME: ID#:

IPA/MEDICAL GROUP: AUTH/PRE CERT #:

DIAGNOSIS DESCRIPTION & ICD-10:

PROCEDURE CONSENT:

CPT -

SPECIAL EQUIPMENT:

ALLERGIES:

PATIENT TYPE: ANESTHESIA: ESTIMATED SURGERY TIME:

SURGERY DATE/TIME:

SURGEON: PROCTOR (IF APPLICABLE):

ASSISTANT: PRIMARY OR REFFERING MD:

H&P COMPLETED BY: BETA BLOCKER: MEDICALLY CLEARED:

WHERE ARE LABS/EKG/X-RAY BEING DONE?:

PATIENT HX OR CURRENT INFECTION: IF SO SITE AND PREVIOUS CONFIRMED DATE:

COMPLETED BY: OFFICE#