SURGICAL/CATHETERIZATION LAB PROCEDURE BOOKING FORM

PATIENT INFORMATION

Name					DOB			Gender		
Address				City			State		Zip	
SSN	SSN		P	Phone #		Phone Ty	pe			
Emergency (Contact		R	Relatio	nship			Phone #		
Preferred Language				E-r	nail Ad	ldress				

PAYER/GUARANTOR

PRIMARY INSURED (IF DIFFERENT THAN PATIENT)

Name		DOB		Gender		
Address	City		State		Zip	
SSN	Phone #	4		Phone Ty	pe	

INSURANCE INFORMATION

Carrier		Group #	
Policy #	Prior Aut	horization #	

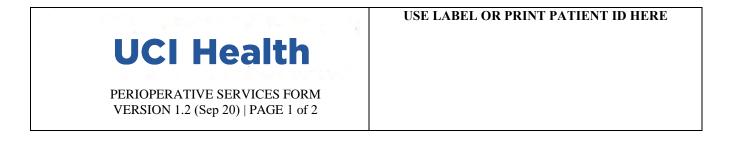
WORKER'S COMPENSATION INFORMATION (IF APPLICABLE)

Workers Comp Rela	Claim #					
Adjuster Name			Adjı	uster Phone #		

PHYSICIAN PRACTICE

Surgeon Name		Office Phone #	
Proctor Required	Proctor Name		

(Continued on next page)



DIAGNOSIS/PROCEDURE

Diagnosis									
Procedure/Surge	ry				Positi	on			
(Please also specific Site/Side when						Ambulation			
procedure will oc	<u>cur)</u>				Statu	s			
CPT Code(s)				ICD-10	Code(s)				
Admit Status			Critical (Care		An	esthesia		
Allergies							·		
Preferred Case Date			Preferred			l Start Time			
Labs Required	Day of Su	rgery	ery Patho			quired			
Instruments &							I		
Equipment Nee	ded								
Implants Neede	d								
Vendor Compa	ny		Name			Pho	ne #		
Other Case Nee									
Notes, and Prefe	erences								
for Consideration	on								

CONTACT CENTRALIZED SCHEDULING (PLEASE SEND VIA FAX OR SECURE E-MAIL)

Phone #	1-833-BOOK-FVR (1-833-266-5387)	Fax #	714-966-3338
Secure E-mail	FVR-Scheduling@tenethealth.com		

