NEWTON MEDICAL CENTER SURGERY SCHEDULING INFORMATION

Patient SSN_____Name_____ DOB_____

Person to Contact _____ Relationship _____

Primary Phone # 1_____ *H/C/W* #2_____ *H/C/W* #3_____ *H/C/W*

Height_____Weight _____BMI_____ Diabetic: YES ☐ NO ☐ Insulin ☐ Non-Insulin ☐

Biological Sex: Male ☐ Female ☐ Unknown ☐

Gender ID: Male ☐ Female ☐ Male to Female ☐ Female to Male ☐

Gender Queer ☐ Other Gender ☐ Declined to answer ☐ No Information Available ☐

Physician _____Date of Procedure _____

Consented Procedure _____

_____

Medical Clearance Needed: YES ☐ NO ☐ Cardiac Clearance Needed: YES ☐ NO ☐

Anesthesia Provider Needed: YES ☐ NO ☐ Pathologist: YES ☐ NO ☐

Location: Newton Medical Center ☐ Newton Surgery Center ☐ Other_____

Admit as: Outpatient/SDC ☐ Outpatient/SDC w/Bed ☐ Inpatient ☐

Scheduling Requests _____

Implant/Graft Type Needed _____

Special Equipment/Sets Needed _____

Vendor _____ Vendor Rep _____ Date/Time Notified _____

Pt position _____Notes _____

CPT Code _____ ICD 10 Code_____

Pre-op Diagnosis _____

Primary insurance _____Policy# _____

Prior Auth required: YES ☐ NO ☐ Auth # _____ Date Range _____

Verified by (Insurance Rep) _____Contact # _____

Printed name of person completing_____Date_____

Please Fax Completed Form to **Surgery Scheduler @ 316-804-6181** and to **Registration Desk @ 316-804-6292**