STONY BROOK UNIVERSITY MEDICAL CENTER

ASC OR ORTHOPAEDIC BOOKING SHEET PHONE # 444-9431 FAX # 444-6452

*** Patient's Contact phone day before surgery**______________________________

PATIENT NAME______________________________ DOB______________ SS#____________________

MRN______________HOME PHONE____________________ WORK /CELL______________________

INSURANCE____________________________AUTH/ REFFERAL#____________________________

DATE OF SURGERY ______________ PHYSICIAN________________________________SVC_______

PHYSICIAN'S CONTACT PERSON & PHONE____

CPT CODE	SURGEON'S PROCEDURE	SITE/ SIDE

SBUMC PROCEDURE: ____

____

ICD9 CODE(S) : ______________________________ DURATION OF SURGERY : __________ HR(S)

CHECK All That APPLY: X-RAY Day of SGY: A) Fluoroscopy LG_____ B) MINI C-ARM ____C) Flat Plate______

LATEX ALLERGY_______ DIABETIC________ PREGNANT_______

	Company	SIZE OF SCREWS	TYPE
IMPLANTS:			
Removals:			
Allograft:			

OTHER SPECIAL EQUIPMENT NEEDED FOR PROCEDURE :

____

DOES PATIENT NEED POS APPOINTMENT AT SBUMC? YES NO

ASA_______**ANESTHESIA CONSULT REQUIRED FOR ADULT PATIENT ASA 3 OR PATIENT LESS THAN 18 YEARS ASA 2 OR 3

POS SERVICES NEEDED: PLEASE CHECK THOSE THAT APPLY – *FOR SCHEDULING PURPOSES ONLY*

***PHYSICIANS MUST USE APPROPRIATE HOSPITAL FORMS FOR ORDERS** * PLEASE FAX ALL TESTING ORDERS TO 444-9536*

POS COMMENTS

ANESTHESIA CONSULT___________EKG__________H & P_________LABS_________

Is this patient either residing in a facility or group home, mentally disabled or on a ventilator?

If yes, provide details____

Office use only

OR SCHEDULED____________________ FAX_________ POS SCHEDULED ____________________PREREG_______

CO-PAY/ DEPOSIT/ DEDUCTIBLE___________BY___________FINANCIAL APPROVAL AND COMMENTS________________________