THE QUEEN'S MEDICAL CENTER
WEST O'AHU

The West Port Program

Port Placement/Removal Request

PATIENT'S NAME (Last, First):	PATIENT CONTACT PHONE(S):	DATE OF BIRTH: MRN (if known):
PATIENT INSURANCE(S): POLICY #:	AUTH OBTAINED: ☐ YES ☐ NO ☐ AUTH NOT REQUIRED AUTH #:	PCP:
LATEX ALLERGY?: ☐ YES ☐ NO	PACEMAKER/AICD?: ☐ YES ☐ NO	>350 lbs?: ☐ YES ☐ NO

Procedure: ☐ Port Placement (36561) ☐ Port Removal (36590)

Comments/Special Requests: ☐ None ☐ Other: _____

Diagnosis w/ICD 10 Codes: _____

H&P/Progress Note: ☐ In CARE*Link ☐ Attached with Request

Requesting Provider:_____Signature:_____Phone #:_____Date: _____

Please FAX completed form to #691-3887. Thank you.

Scheduling Office #: 691-3288

For Office Use Only

SCHEDULED BY:	SURGERY DATE/TIME:	PATIENT NOTIFIED: □ Yes Date: _____

Created 3/17, revised 4/13/17, 5/17/17