THE QUEEN'S MEDICAL CENTER
WEST O'AHU

Surgical Services Scheduling Form

Phone #: 691-3288 / Fax #:691-3887

PREFERRED SURGERY/PROCEDURE DATE: ____ / ____ / ____ REQUESTED IN TIME: ______:______

SURGEON: ____ REQUESTED AMOUNT OF TIME: ______

SENDER: ____ CALL BACK PH #: _________________

PATIENT NAME: __________________________________ DOB: _______ / _______ / ________

QMC MRN # (IF AVAILABLE) _______________________ SS#: ________ - ________ - ________

LOCATION (CIRCLE ONE): OPERATING ROOM ENDOSCOPY ROOM

PATIENT CLASS (CIRCLE ONE): OUTPATIENT SURGERY SURGICAL ADMIT INPATIENT

PROCEDURE DESCRIPTION: ____

CPT CODE(S): ____

EQUIPMENTS/INSTRUMENTS/SPECIAL REQUESTS: ____

____

DIAGNOSIS: ____

ICD 10 CODE (S): ____

LATEX SENSITIVE ? _________ > 350 LB? _________ PACEMAKER/ICD? ________ HD? _________________

PATIENT PH #: (HOME) ________________ (WORK) ________________ (CELL) ________________________

INSURANCE (S): ____

1ST ASSISTANT: ____________________________ 2ND ASSISTANT: ____________________________

ANESTHESIOLOGIST: HOUSE: ____ OTHER: ____

REFERRING DR: ______________________________ **PCP:** ___________________________________

QMC / SCHEDULED BY: _____________________ DATE/TIME ENTERED: ___ / ___ / ___ @ ___ : ___

****PLEASE FAX BACK TO : __________________ FOR CONFIRMATION CASE IS SCHEDULED****