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: West GI provider REQUESTED AMOUNT OF TIME: 30 min

SENDER: ______________________ CALL BACK PH #: ______________

PATIENT NAME: ______________________ DOB: ______ / ______ / ______

QMC MRN # (IF AVAILABLE) ______________ SS#: ______ - ______ - ______ (optional)

LOCATION (CIRCLE ONE): OPERATING ROOM X ENDOSCOPY ROOM

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

PROCEDURE DESCRIPTION: Esophageal Manometry

CPT CODE(S): 91010

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****