Nadora Healthcare

PHYSICIAN'S ORDERS

SURGERY SCHEDULING FORM

Today's Date: _____

Scheduling fax: 970-663-4227 Phone Number: 970-663-3200

Office Scheduler: _____ Phone: _____ Fax: _____

Patient SS#: _____ Date of Birth: _____Gender at Birth M_____ F_____
Patient identifies as M_____F_____

Legal Last Name: _____ First: _____ Full Middle: _____

If Patient is a Minor, Legal Guardian's Name: _____

First Name Patient Would Prefer To Be Acknowledged As: _____

Patient's Address: _____City:_____ State: _____ Zip: _____

Home Telephone: _____Cell/ Alt Number: _____ Email: _____

Primary Insurance: _____ ID#: _____ Group#:_____ Auth: _____
Secondary Insurance: _____ ID#: _____ Group#:_____ Auth: _____

Surgeon: _____Date of Surgery: _____Time Requested: _____ Duration: _____
Assistant: _____ Patient Status: ☐ 24-72 hour overnight stay ☐ Outpatient ☐ Other: _____

Pre-Operative Diagnosis_____ ICD10:_____
Surgical Procedure/Consent to Read (No Abbreviations) ☐Right ☐Left ☐Bilateral

_____CPT Code_____

_____CPT Code _____

_____CPT Code_____

Special Needs- Equipment/Implants: _____
☐C-Arm ☐Cell Saver ☐ Neuro Monitoring ☐ Vender Needed in OR:_____

Pacemaker/AICD Present: ☐ Yes Hearing Impaired: ☐ Yes. Interpreter Needed? ☐ Yes. Language if not English: _____
Allergies: _____Latex Allergy ☐Yes ☐No
Metal Allergy ☐ Yes ☐No

Anesthesia Request/Consult: _____Anesthesia Type: _____