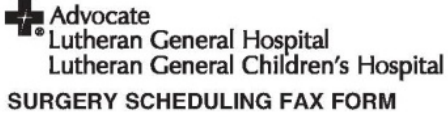
☐ New Case   Requested Surgery Date: ______________ Time: ______________
☐ Request Change to existing case   Original date and time: __________________
Reschedule Date: ____________________ Time: ____________________
☐ Currently an Inpatient   Isolation Precaution ____________________
Surgeon: ______________________ Assistant: ______________________
Admitting MD: ______________________

Facsimile: 847.723.2249
PST Phone: 847.723.7372
Scheduling Phone: 847.723.5200

Section	Details
Patient	Name: ______ Last / First / Middle Initial Date of Birth: ______ ☐ M ☐ F Address: ______ City______ Zip ______ Social Security Number: ______ ☐ Interpreter/Language ______ Latex Allergy? ☐ Yes ☐ No ☐ Unknown Other Allergy: ______ Primary Phone: ______ Secondary______ ☐ Insurance Company ______ Group ______ Policy No______ ☐ Workmen's Comp Case Number: ______
Admission Type	☐ Outpatient ☐ Inpatient ☐ SDA (Inpt) ☐ MOR ☐ ASC Post op: ☐ Home ☐ Floor ☐ ICU
Procedure	Diagnosis Procedure (including implants) / Consent to read: Minutes needed: ______ ICD Code: ______ CPT Code:______
Operating Room Prep	**Special Equipment:** ☐ SSEP ☐ MEP ☐ Cell Saver ☐ Navigation ☐ Laser ☐ Facial Nerve monitoring ☐ Table ______ ☐ Other ______ ☐ Patient position: ______ Assistant needed ☐ Yes ☐ No **OR Imaging:** ☐ C-arm ☐ C-arm x2 ☐ Dental ☐ Flat Plate ☐ Fluoroscan / Mini-C arm ☐ O-Arm ☐ **Xray / films needed in OR:** Date of Study ______
Anesthesia	☐ General ☐ MAC ☐ Local ☐ Spinal ☐ Epidural ☐ Conscious Sedation ☐ Block ______
Pre-Surgical Testing / Blood Orders	Height _____ Weight _____ PCP:______ Cardiologist______ ☐ H&P by: ______ Date: ______ Time:______ **Co-Morbidity requiring pre-testing:** ☐ Heart Disease ☐ Insulin/Diabetes ☐ Resp Disease ☐ Anti-coag **Requires:** ☐ Medical Clearance: ☐ Cardiac Clearance: ☐ Testing per Advocate Guideline ☐ Testing done at: ______ **Pre-op Testing:** ☐ CBC ☐ PT/PTT (recent anti-coagulant use) meds: ______ ☐ BLOOD: (units): ______ ☐ CMP ☐ Type/Screen ☐ BMP ☐ Other Lab Work ☐ Type/Cross PRBC____units ☐ Autologous ______ units ☐ Glucose ☐ PT/INR ☐ MRSA Swab ☐ Designated Donor____units ☐ Platelet____ packs ☐ K+ ☐ EKG ☐ HCG Urine ☐ CXR
Preventive Care/ Pre Op Orders	**Antibiotics:** ☐ Pre-op Prophylaxis per Advocate guideline ☐ Alternate pre-op prophylaxis **Beta Blocker:** ______ **Venous Thromboembolism Prophylaxis:** ☐ TEDS ☐ SCD's ☐ AV impulse Other Orders
Signature	Physician Signature ______ Date/Time______

Advocate Office use only: Scheduled on:______ by:______ Reviewed by:______ on:______
Conf number: ______



SURGERY SCHEDULING FAX FORM

Print   Clear Form

91-1288 05/11

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