☐ SCMC Surgeons Choice Medical Center 248.423.5159 FAX 248.423.5195

☐ SCMC Surgeons Choice Macomb Center 248.423.5159 FAX 248.423.5195

☐ New Surgical Boarding ☐ Rescheduling ☐ Cancellation ☐ Revised

SURGICAL BOARDING AND ADMISSION INFORMATION (Revision 04/2021)

DOCTOR: _____

OFFICE CONTACT: _____

CONTACT NUMBER: _____

PRIMARY CARE PHYSICIAN_____

ALLERGIES:

☐ OUTPATIENT HEIGHT_____

☐ ADMISSION WEIGHT_____

☐ POSSIBLE OBSERVATION

ADMISSION REQUESTS *MUST* BE INCLUDED IN THE AUTHORIZATIONS

SURGERY REQUIREMENT ≥ 13 YEARS OLD AND ≥ 90 LBS

ADMISSION REQUIREMENT > 17 YEARS OLD

☐ THIS PATIENT RESIDES IN A SKILLED NURSING FACILITY

REQUESTED DATE OF SURGERY: _____

LENGTH OF PROCEDURE: _____

NAME: _____

SOCIAL SECURITY #: _____

DOB: _____ AGE:_____

☐ MALE ☐ FEMALE

HOME PHONE: _____

ALTERNATE PHONE: _____

ADDRESS: _____

_____

EMAIL ADDRESS: _____

ANESTHESIA: ☐ GENERAL ☐ LOCAL ☐ LOCAL/GENERAL ☐ LOCAL/SEDATION ☐ BLOCK ☐ CHOICE

☐ SEDATION ONLY POST-OP PAIN MANAGEMENT: ☐ SINGLE SHOT ☐ CATHETER PLACEMENT

PATIENT POSITION: ☐ PRONE ☐ SUPINE ☐ LATERAL ☐ OTHER

DIAGNOSIS (CPT CODE AND DESCRIPTION REQUIRED):

_____

PROCEDURE (CPT CODE AND DESCRIPTION REQUIRED):

_____

_____

_____

INSURANCE INFORMATION:

(COPIES OF AUTHORIZATIONS, INSURANCE AND ID CARDS (MUST BE SUBMITTED 2 DAYS PRIOR TO SURGERY)

INS CARRIER: _____ EFFECTIVE DATE: _____ GROUP #: _____

INS CONTACT: _____ CONTACT #: _____

SPECIAL EQUIPMENT:

PROSTHETIC/ IMPLANT REQUESTED BY SURGEON: _____

SPECIAL/ OTHER EQUIPMENT: _____

FOR ORH STAFF ONLY: EQUIPMENT ORDERED: ☐ YES ☐ NO DATE ORDERED: INITIALS: