BARMISC

NMC health
PO Box 308 | Newton, KS 67114

NMC Health Surgery Scheduling Information

1) Demographics	
SSN	
Name	
DOB	
Biological Sex	☐ Male ☐ Female ☐ Unknown
Address	

2) Contact		
Primary #1 H/C/W	**Phone #2 H/C/W**	**Phone #3 H/C/W**
#	#	#
Individual name:	**Individual name**:	**Individual name**:
Relationship: ☐ Self (pt) ☐ Nursing Home Staff ☐ Parent ☐ Spouse ☐ Significant Other ☐ Other	**Relationship**: ☐ Self (pt) ☐ Nursing Home Staff ☐ Parent ☐ Spouse ☐ Significant Other ☐ Other	**Relationship**: ☐ Self (pt) ☐ Nursing Home Staff ☐ Parent ☐ Spouse ☐ Significant Other ☐ Other

3) Health & Procedure	Height	Weight	BMI
Diabetic: ☐ Yes ☐ No ☐ Insulin ☐ Non-Insulin	**Medical Clearance Needed:** ☐ Yes ☐ No **Cardiac Clearance Needed:** ☐ Yes ☐ No	**Blood transfusion:** ☐ Likely ☐ Unlikely	**Preop COVID-19 Testing** ☐ Yes ☐ No ☐ Refused

Surgeon:	**Consented Procedure:**		
Date of Procedure:	**Registration Type:** ☐ Outpatient/ SDC ☐ Outpatient/ SDC w/ Bed ☐ Inpatient	**Vendor Company:** **Vendor Personnel:**	**Date/Time Rep Notified:**
Patient Positioning: ☐ Supine ☐ Lateral ☐ Prone ☐ Beach Chair ☐ Lithotomy ☐ Other:		**Implant/Graft Type Needed:**	
Requested Staff: ☐ CRNA/ Anesthesia ☐ RN Monitor/ Moderate Sedation (non-anesthesia provider) ☐ First Assist _____ ☐ Pathologist (Frozen/Fresh Specimen)		**Specialty Equipment/Sets Needed:**	
Scheduling Requests: Time ☐ Move Up ☐ Move Down **Estimated Case length:**		**Edit Scheduling** ☐ Place on Hold ☐ Reschedule Date ☐ Cancel	**Date change made & initial** _____ _____

4) Registration Insurance			
CPT Code		**ICD 10 Code**	
Pre-op Diagnosis			
Primary Insurance Company			
Prior Auth required	☐ Yes ☐ No	**Auth #**	**Date Range:**
Verified by (Insurance Rep)		**Contact #**	

Printed Name of person completing _____ Date_____

Please fax Completed Form to Surgery Scheduler @ 316-804-6181 and to Registration Desk 316-804-6167 ***Doc ID #19351***