SSF

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	**Assisting Surgeon:**
Surgeon:	**Consented Procedure:**	
Date of Procedure:		

Registration Type: ☐ Outpatient/ SDC ☐ Outpatient/ SDC w/ Bed ☐ Inpatient	**Edit Scheduling:** ☐ Place on Hold ☐ Reschedule Date ☐ Cancel	**Reschedule Date:**	**Scheduling Requests:** Requested Time _____ ☐ Move Up ☐ Move Down ☐ Don't Move **Estimated Case length:**

Requested Staff: ☐ CRNA (Anesthesia) ☐ RN Monitor (x2 RNs) ☐ Moderate Sedation (non-anesthesia provider with x2RNs) ☐ Local (only x1 RN) ☐ First Assist _____ ☐ Pathologist (Frozen/Fresh Specimen)	**Specialty Equipment/Sets Needed:**
	Implant/Graft Type Needed:

Patient Positioning: ☐ Supine ☐ Lateral ☐ Prone ☐ Beach Chair ☐ Lithotomy ☐ Other:	**Vendor Company:** **Vendor Personnel:**	**Date/Time Rep Notified:**

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_____

Fax Completed Forms to Surgery Scheduler @ (internal #9) 1-316-804-6181 and to Registration Desk 1-316-804-6167 ***Doc ID #19351***