SURGERY SCHEDULING REQUEST FORM

900 N. MICHIGAN SURGICAL CENTER

60 East Delaware Place, 15th Floor, Chicago, IL 60611
Phone: (312) 440-5150 or (312) 440-5152 ext. 314
Fax: (312)440-5156

Surgeon/ Assistant:_____
Pre-Op Diagnosis/(ICD-9): _____

_____

Procedure/(CPT):_____

_____

Date of Surgery:_____ Surgery Time:_____ Surgery Duration:_____
Anesthesia Requested: General□ MAC/ IV Sed□ Spinal□ Local□
Other:_____
Special Instruments or Equipment Requested: _____

_____

PLEASE LIST ANY SPECIAL NEEDS PATIENT MAY HAVE

(language barrier, cultural/religious requests, mobility or vision limitations, hearing impairment etc.)

☐ NONE

Patient Information

Name:_____
Address:_____
_____County:_____
Home Phone:_____
Work Phone: _____
Birth date:_____ Age:_____
Sex:_____ Marital Status: _____
SS#:_____

Insurance Information

Insurance:_____
Insured Name:_____
Insurance Phone:_____
Insured SS#:_____

Patient History

Height:_____ Weight:_____
Allergies:_____

History of:	Yes	No
High Blood Pressure	□	□
Heart Attack/ Murmur	□	□
Stroke	□	□
Diabetes	□	□
Asthma/Emphysema	□	□
Recent Hospitalization	□	□

Use of the following medications?

☐ Blood Pressure
☐ Heart Pills
☐ Diuretic
☐ Blood thinners
☐ Insulin
☐ MAO Inhibitors

Please fax Labs to (312) 440-5156

NOTE: Patient Ethnicity and Race information are mandated by State of Illinois

Ethnicity: □ HISPANIC □ NON HISPANIC

Race: □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN
□ BLACK OR AFRICAN AMERICAN □ NATIVE HAWAIIAN OR PACIFIC ISLANDER
□ WHITE □ OTHER

☐ YES ☐ NO **Patient received Center's information packet including Patient Rights and Responsibilities, and financial interest disclosures, if applicable.**

☐ **Check if patient has any form of advance directives.**

Same Day Scheduling Only Physician Statement: procedure(s) as scheduled above are consistent with pre-op diagnosis and appropriate for outpatient setting and

☐ prompt intervention is medically necessary, or procedure type cannot be scheduled in advance (e.g. IVF)

☐ for personal reasons patient cannot schedule elective procedure at other time. Postponement could be indefinite and could limit patient access to desired medical services.

SURGEON'S SIGNATURE:

Completed by:_____ Date:_____