



**AMBULATORY SURGERY RESERVATION FORM**

DATE OF PROCEDURE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ESTIMATED TIME: \_\_\_\_\_ AM / PM

Status:      Ambulatory      Elective      Urgent / Transfers      Accommodations: \_\_\_\_\_

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BI MR #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Did patient have previous Bypass?  Yes  No If yes, please indicate where? \_\_\_\_\_

**EMERGENCY CONTACT:**

Name (Last, First): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION:**

**\*\*Primary Insurance:** \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Category #: \_\_\_\_\_  
**PRE-AUTHORIZATION #:** \_\_\_\_\_ **REFERRAL #:** \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Category #: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PROCEDURE:**

Type of Procedure: \_\_\_\_\_ Type / Code \_\_\_\_\_ Type / Code \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_  
**Referring Physician:** \_\_\_\_\_ **Primary Physician:** \_\_\_\_\_  
Referring Physician Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Attending Physician:** \_\_\_\_\_

**TRANSFER INFORMATION:**

Hospital: \_\_\_\_\_ Pick-up Time: \_\_\_\_\_  
Transferring MD: \_\_\_\_\_ BI Bed #: \_\_\_\_\_  
Room/Bed #: \_\_\_\_\_ Transport Company / Authorization #: \_\_\_\_\_  
RN Contact: \_\_\_\_\_ Monitor? Yes No Oxygen? Yes No  
Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Heplock? Yes No IV? Yes No  
Coumadin? Yes No **Diabetic?** Yes No

**PRE-ADMISSION TESTING INFORMATION:**

**Tests Ordered:** CBC W/Platelets SMA-7 PT PTT INR SERUM BETA HcG **\*Must be less than 30 days\***  
\* DATE OF LAST EKG: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ \* DATE OF LAST BLOODWORK: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
WHERE DONE: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

RESERVATION TAKEN BY: \_\_\_\_\_ PHONE #: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

EXPEDITER INITIALS: \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DATE SENT TO RESERVATIONS: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CONFIRMED W/PT: \_\_\_\_ / \_\_\_\_ / \_\_\_\_