



**OR / PROCEDURE POSTING INFORMATION and/or BED REQUEST**

PATIENT NAME: LAST FIRST MIDDLE

SOC SEC # \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
PRECERT REQ  YES  NO  
PRECERT # \_\_\_\_\_  
SECOND OPINION REQ  YES  NO  
REFERRAL OBTAINED FROM PRIMARY MD  Y  N

DATE OF BIRTH AGE SEX MR #

**OR / PROCEDURE POSTING INFORMATION**

PROCEDURES ARE:  SIMULTANEOUS  **AMBULATORY** PT HOME FROM PCS / ACC DAY OP = "D"  
 CONSECUTIVE  **INPATIENT**. (PT IN HOUSE ALREADY = "I") MULTIPLE SERVICE CASES  
PRIMARY SERVICE FAXES BOTH  
POSTING SLIPS, MARK 1 OF 2, 2 OF 2

PROCEDURE DATE SERVICE CARD#

ATTENDING MD CODE: NAME: RESIDENT MD CODE: NAME:

CASE  ELECTIVE  ADD ON (NON EMERGENCY) PREFERRED  MAIN HOSPITAL  WOMEN'S AND CHILDREN  
TYPE  EMERGENCY (NON-TRAUMA)  EMERGENCY (TRAUMA) LOCATION  AMBULATORY CENTER  
 CYSTO  RADIOLOGY

OPERATING ROOM REQUESTED TIME REQUEST ESTIMATED LENGTH (IN MINS)  ACC UNACCEPTABLE

PRIMARY CPT CODE DESCRIPTION L R BIL

SECONDARY CPT CODE DESCRIPTION L R BIL

SECONDARY CPT CODE DESCRIPTION L R BIL

ANESTHESIA:  NONE  LOCAL  GENERAL  REGIONAL  MAC  CONSCIOUS SEDATION

POSITION FOR PROCEDURE: (COMPLETE ONLY IF NOT ROUTINE)  SUPINE  PRONE  LATERAL  LITHOTOMY  TABLE TURNED

SPECIAL NEEDS: (BLIND, HARD OF HEARING, PROSTHETICS, PACEMAKER, ETC.) SUPPLIES OR EQUIPMENT (SPECIAL ORDERS, RENTALS, TABLES, POST OP SPECIALTY BEDS)  NA

ISOLATION PRECAUTIONS:

ADMITTING DIAGNOSIS PRE-OP:

SX / PRESENTING PROBLEMS / DURATION:

D/C PLANNING:

PATIENT NOTIFICATION INFORMATION NIGHT BEFORE SURGERY: LAST NAME, FIRST NAME, PLACE AND PHONE #:

**BED REQUEST**

ARRIVAL DATE / / LOS

**SAME DAY ADMISSION = (SDA)=S** REQUIRES PHYSICIAN ORDER "ADMIT" TO INPATIENT

PRE OP DAY  YES  NO REASON FOR PRE OP DAY; \_\_\_\_\_

**EXTENDED STAY = E** (23 HRS. MAX) PT. WILL REQUIRE MORE THAN ROUTINE 4-6 HR RECOVERY PERIOD FOLLOWING AN OUTPATIENT PROCEDURE DUE TO EXTENUATING CIRCUMSTANCES (HIGH RISK CANDIDATE, HISTORY OF COMORBIDITIES, ETC.) REQUIRES PHYSICIAN ORDERS OF EXTENDED STAY, REASON PT. REQUIRES EXTENDED STAY: \_\_\_\_\_

PRIOR APPROVAL HAS BEEN COMPLETED  YES  NO # \_\_\_\_\_

HOSPITAL SERVICE ADMITTING ATTENDING CARE TYPE:  ICU  Stepdown  Floor

CONSULTS

TREATMENT  SURGERY: IF YES, COMPLETE OR POSTING INFORMATION

PLAN  OTHER: SPECIFY \_\_\_\_\_

FAX TO PRE-CERTIFICATION: 962-3049 AND/OR SCHEDULING OFFICE:

966-3797

CONTACT RESIDENT TO CALL FOR QUESTIONS: POSTING SLIP COMPLETED BY: PAGER DATE  
NAME PAGER NAME PAGER