



University of North Carolina Hospitals
Chapel Hill, NC 27514

* IF PATIENT HAS NO MR#
CALL 1-800-634-8020 TO
REGISTER PT/OBTAIN MR#

OR / PROCEDURE POSTING INFORMATION and/or BED REQUEST

PATIENT NAME: LAST FIRST MIDDLE
 DATE OF BIRTH AGE SEX MR #
 SOC SEC # _____
 INSURANCE COMPANY _____
 PRECERTREQ YES NO
 PRECERT # _____
 SECOND OPINIONREQ YES NO
 REFERRAL OBTAINED FROM PRIMARY MD Y N

OR / PROCEDURE POSTING INFORMATION

PROCEDURES ARE: SIMULTANEOUS CONSECUTIVE
 AMBULATORY PT HOME FROM PCS / ACC DAY OP = "D"
 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: 966-3197

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