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 _____
PRECERT REQ ☐ YES ☐ NO
PRECERT # _____
SECOND OPINION REQ ☐ 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 ☐ AMBULATORY CENTER
TYPE ☐ EMERGENCY (NON-TRAUMA) ☐ EMERGENCY (TRAUMA) _____ LOCATION ☐ 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:
NAME PAGER

POSTING SLIP COMPLETED BY:
NAME PAGER DATE