Robert Wood Johnson University Hospital Somerset | RWJBarnabas HEALTH

Place patient ID sticker here.

O.R. SCHEDULING FAX: 908-685-2431

PATIENT INFORMATION: (REQUIRED)

Last Name: ______________________ First Name: ______________________

Preferred Name: ______________ Preferred Pronoun: ☐ He ☐ She ☐ Other:______________

Sex at Birth: ☐ Female ☐ Male ☐ Other:__________ DOB:______________ SSN:______________

Current Gender Identity: ☐ Female ☐ Male ☐ Other:__________ (Confirm Preferred Name, Sex at Birth and Gender Identity with EMR)

Home Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone: ______________ Cell: ______________ Work: ______________

Email: ______________________ Preferred Language: ☐ English ☐ Spanish ☐ Other__________

PROCEDURE INFORMATION: (REQUIRED) **Required information

Primary Surgeon: ______________________ Secondary Surgeon: ______________________

First Assistant: ☐ Yes ☐ No Patient Type: ☐ Same Day ☐ Admission ☐ In-Patient

**Diagnosis: ______________________________ **DX # ______________

**Intended Procedure: ______________________________ **CPT #______________

Modifier: ☐ Right ☐ Left ☐ Bilateral ☐ Other: ______________________

Anesthesia: ☐ General ☐ MAC ☐ Spinal ☐ Local (ASA 3 or 4 require MAC) Notes:______________

Post Op Pain: ☐ Nerve Block ☐ OnQ Pain Ball ☐ Epidural ☐ TAP ☐ PECS Notes:______________

Latex Allergy: ☐ Yes ☐ No Patient has: ☐ AICD ☐ Pacemaker (attach ID card to booking)

X-Ray Request: ☐ C-Arm ☐ 2nd C-Arm ☐ Mini C-Arm ☐ Portable

Special Equipment Requested: ____

Insertion of Urinary Catheter: ☐ Yes ☐ No Name of Urologist: ______________________

Procedure duration estimated in minutes: __________ ☐ Routine ☐ Complex (requesting additional time)

Date Requested: ______________________ Time Requested: ______________________ AM / PM

INSURANCE INFORMATION: (REQUIRED) *****Please provide exact Name of Insurance company and avoid using "Misc Insurance"***

Primary: ______________________ Pre Cert/Referral: ______________________

Group #: ______________________ Policy #:______________________

Address & Phone # of Insurance Company: ____

****Insurance contact information: Phone # ______________ Fax Clinical to # ______________.**

****Authorization # with approved status [Inpatient or Same Day Surgery]:______________________.**

Name of Insured if other than self: ______________________ DOB: ______________

SSN: ______________________

Secondary: ______________________ Pre Cert/Referral: ______________________

Group #: ______________________ Policy #: ______________________

Address & Phone # of Insurance Company:____

****Insurance contact information: Phone # ______________ Fax Clinical to # ______________.**

****Authorization # with approved status [Inpatient or Same Day Surgery]:______________________.**

Name of Insured if other than self: ______________________ DOB: ______________

SSN: ______________________

Workers Comp/MVA Insurance: Claim#:______________________ Date of Injury:______________

Adjuster's Name & Phone #: ____

SCHEDULING DEPT USE ONLY: **Completed By:** ______________________

Patient Scheduling Complete: ☐ Yes ☐ No Comments: ______________________