Ortho Nebraska

ELECTRONIC SURGERY SCHEDULING FORM

RED BOXES INDICATE REQUIRED FIELD

Patient Demographics	**INTERPRETER NEEDED** No	**LANGUAGE**		
FIRST NAME	**LAST NAME**	MI	**DATE OF BIRTH** dd/mm/yyyy	**GENDER**
PRIMARY PHONE # **Type**	SECONDARY PHONE # Type	THIRD PHONE # Type	**SOCIAL SECURITY #**	

Insurance Information	***Please attach front and back copy of patient's insurance card(s)***
PRIMARY INSURANCE COMPANY	**POLICY #**
GROUP # / **PRE-CERT #**	**CONTACT**
SECONDARY INSURANCE COMPANY	**POLICY #**
GROUP # / **PRE-CERT #**	**CONTACT**

Surgery Scheduling Detail	**Surgery Date:** **Time:**	**Surgery Length:**
ADMITTING PHYSICIAN	**Patient Admission Status to be:**(Select One) ◯ Outpatient ◯ Inpatient	
PRIMARY CARE PHYSICIAN	◉ N/A **If Outpatient:** Bed Management ◯ No ◯ Yes	
	◉ N/A **If Inpatient:** Expected Length of Stay ◯ 1 day ◯ 2 days ◯ 3 days ◯ 4 days	
DIAGNOSIS	**ICD**	**ANESTHESIA TYPE** Axillary Block
Rt/Lt/Bil Procedure #1		**CPT**
Rt/Lt/Bil Procedure #2		CPT
EQUIPMENT / HARDWARE / IMPLANTS / COMPANY / SPECIAL INSTRUCTIONS		
Preoperative Order Sets Click to Select		Referred to: ☐ Primary Care ☐ Cardiology ☐ Pulmonary

OFFICE INFORMATION		
OFFICE CONTACT	**OFFICE PHONE #**	SCHEDULED POST-OP VISIT Date: Time:
PHYSICIAN SIGNATURE		**Date:** **Time:**

Bold items required

Updated Feb 2019