Mountainside Hospital
Surgical/Endoscopy Scheduling Request Form

FAX TO O.R. SCHEDULING: 973-680-7946 **REVISED ON:_____**

Confirmation#_____

DOS:_____ Procedure Time:_____ **Scheduler's Name:_____**

Physician:_____ **Assistant:_____**

Patient Name:_____
Last First MI

DOB:_____ **Sex:_____** **SS #_____**

Address:_____
Street Apt. #

_____ _____ Phone:(Home)_____
City State Zip Phone:(Cell)_____

Admission Type: **SDS___ EAM___OPR(23Hr)____**

Procedure:_____

Procedure Code(s): _____ Diagnosis Code(s): _____
Requested Case Length:_____ **Right____Left____Bilateral____**

Anesthesia Type: **General ___ MAC /IVCS____Local ___Spinal ___Epi ___Block (Specify) _____**

Pre Admission Testing Date:_____ Time:_____

Physician Signature:

Pre Admission Tests Ordered: (Please Circle)

1- Urinalysis	**13- PSA**	**37- No PAT 's Required**
2- CBC/DIF	**14- Type & Screen**	**38- PAT's Done Off Site**
3- CCA-18	**15- Type & Crossmatch**	**39- Pull Old Chart**
4- Lytes	**16- Autologous**	**40- PAT's to be faxed**
5- Lytes Plus	**20- C&S**	**42- Cell Saver**
6- PT	**21- EKG**	**43- INR**
7- PTT	**22- Chest X-Ray**	**44- Blood levels-seizure meds**
8- ESR	**25- Incentive Spirometry**	**45- H&H**
9- CEA	**30- Liver Function**	**54-COSMETIC SURGERY**
10- CA-125	**32- PCA**	**55-PACEMAKER/AICD**
11- Serum Beta HCG	**33- Other**	**56-LATEX ALLERGY**
12- RPR (VDRL)	**36- Stat Day Of Surgery**	**57-Bariatric PAT Protocol**

NEEDS INTERPRETER?
_____ Signing
_____ Language

Comments/Special Requests:_____

Insurance Information : _____
FAX PAT RESULTS TO PRIMARY:_____FAX #(___)_____
H&P TO BE PROVIDED BY:_____Office phone #(___)_____

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