COFFEE REGIONAL MEDICAL CENTER

PRE−SURGICAL CASE REQUEST

CALL TO SCHEDULE CASE AT EXT 6919

Fax Case Request to OR @ 383−5632 and Registration @ 389−2165

1SCR

DATE:	PATIENT NAME:		Surgeon:
DOB:	SOCIAL SECURITY #:	SEX:	PRIMARY CARE PHYSICIAN:
PATIENT PHONE #:		PREADMIT DATE:	PREADMIT TIME:
SURGERY DATE:	SURGERY TIME:	SURGERY DURATION:	
HEIGHT		WEIGHT	

CLINICAL INFORMATION

1	PATIENT TYPE ❑ OPS ❑ IP STATUS ❑ ELECTIVE ❑ URGENT	URGENT JUSTIFICATION:
2	DIAGNOSIS CODES (ICD10)− SURGERY AND TESTING	DIAGNOSIS DESCRIPTION
3	PROCEDURE CODES	PROCEDURE DESCRIPTION
4	SPECIAL EQUIPMENT INSTRUCTIONS: ❑ C− ARM ❑ X − RAY ❑ PATHOLOGY ❑ IMPLANTS_____ −VENDOR_____ −Rep Phone#	ADDITIONAL SPECIAL INSTRUCTIONS: ❑ Post OP Bed Required ❑ Post OP Critical Care Bed Required ❑ Other: _____ _____

INSURANCE: _____ POLICY NUMBER:_____ ❑APPROVED ❑DENIED ❑PENDING

AUTH/REF #: _____

Call to schedule case @ EXT 6919−OR / 6918−Cath Lab/Day Surgery
Fax Case Request to OR @ 912−383−5632 Registration @ 866−498−1972 ❑Day Surgery @ 912−383−5663❑Cath Lab @ 912−383−5664

Patient Care Director Notified (if applicable): ❑ Yes ❑ No Comments:_____
(PCD to be notified of all Add−ons after 5:30pm M−F & Weekends)

Form Completed By:	Faxed By:	Date/Time:

OR_7095_EFR
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