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SURGICAL/CATHETERIZATION LAB PROCEDURE BOOKING FORM

PATIENT INFORMATION

Name		**DOB**		**Gender**	(Select)		
Address		**City**		**State**		**Zip**	
SSN		**Phone #**		**Phone Type**	(Select)		
Emergency Contact		**Relationship**		**Phone #**			
Preferred Language		**E-mail Address**					

PAYER/GUARANTOR

PRIMARY INSURED (IF DIFFERENT THAN PATIENT)

Name		**DOB**		**Gender**	(Select)		
Address		**City**		**State**		**Zip**	
SSN		**Phone #**		**Phone Type**	(Select)		

INSURANCE INFORMATION

Carrier		**Group #**	
Policy #		**Prior Authorization #**	

WORKER'S COMPENSATION INFORMATION (IF APPLICABLE)

Workers Comp Related Procedure	(Select)	**Claim #**	
Adjuster Name		**Adjuster Phone #**	

PHYSICIAN PRACTICE

Surgeon Name		**Office Phone #**	
Proctor Required	(Select)	**Proctor Name**	

(Continued on next page)

USE LABEL OR PRINT PATIENT ID HERE

DIAGNOSIS/PROCEDURE

Diagnosis					
Procedure/Surgery (Please also specify the Site/Side where procedure will occur)		**Position**	(Select)		
		Ambulation Status			
CPT Code(s)		**ICD-10 Code(s)**			
Admit Status	(Select)	**Critical Care**	(Select)	**Anesthesia**	(Select)
Allergies					
Preferred Case Date		**Preferred Start Time**			
Labs Required Day of Surgery	(Select)	**Pathology Required**	(Select)		
Instruments & Equipment Needed					
Implants Needed					
Vendor Company		**Name**		**Phone #**	
Other Case Needs, Notes, and Preferences for Consideration					

CONTACT CENTRALIZED SCHEDULING (PLEASE SEND VIA FAX OR SECURE E-MAIL)

Phone #	1-833-BOOK-FVR (1-833-266-5387)	**Fax #**	714-966-3338
Secure E-mail	fvscheduling@hs.uci.edu		

UCI Health

PERIOPERATIVE SERVICES FORM
VERSION 1.2 (Sep 20) | PAGE 2 of 2

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