Check Spelling | Save Form | Print Form

SURGICAL/GI PROCEEDURE 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 pocedure	(Select)	Claim #	
Adjuster Name		Adjuster phone #	

PHYSICIAN PRACTICE

Surgeon name		Office phone #	
Proctor required	(Select)	Proctor name	

(Continued on next page)

UCI Health	**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 #	(562) 602-6748	Fax #	(562) 272-6433
Secure E-mail	LWscheduling@hs.uci.edu		

UCI Health	**USE LABEL OR PRINT PATIENT ID HERE**

Check Spelling Save Form Print Form