St. Charles HEALTH SYSTEM

Today's Date : _____

UROLOGY SCHEDULING SHEET

☐ Bend	☐ Redmond	☐ Prineville	☐ Madras
Fax: 541-706-6342 Phone: 541-706-7788	Fax: 541-526-6568 Phone: 541-526-6503	Fax: 541-416-9942 Phone: 541-447-8346	Fax: 541-460-4070 Phone: 541-460-4083

PATIENT INFORMATION

Patient Last Name: _____ First Name: _____ MI: _____
DOB: _____ Gender: ☐Female ☐Male Last Four Digits Of SSN: _____
Patient Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Pt. Preferred Number: ☐Home ☐Cell ☐Work Best Time To Call Pt: ☐Morning ☐Afternoon ☐Evening
Interpreter Needed: ☐Yes ☐No Language: _____

Insurance Company Name: _____ Policy #_____
Medicare: ☐Yes ☐No Authorization / Pre Certification Number: _____

SURGERY INFORMATION

Surgery Date: _____ Surgeon: _____ Assistant:_____
Secondary Surgeon: _____
Surgeon's Scheduler Name: _____ Direct Phone: _____
ICD(s): _____ CPT(s): _____
Working Diagnosis: _____
Procedure:☐Left ☐Right ☐Bilateral _____
_____

☐Inpatient / ☐Outpatient / ☐Current In Patient - Room #: _____ Time Required (Cut to Close): _____
Position For Surgery: ☐Supine / ☐Lateral / ☐Beach Chair / ☐Prone / ☐Sitting / ☐Lithotomy
Approach: ☐Laparoscopic ☐Open
Anesthesia: ☐General / ☐Spinal / ☐MAC / ☐Local / ☐Bier / ☐Moderate Sedation / ☐Other: _____
Instrumentation: _____
Special Order - Type:_____ Size: _____Manufacturer: _____
Vendor Rep Notified: ☐Yes ☐No Rep Name: _____ Phone #: _____

Implant: _____ Implant Authorization No. _____

Table:	☐Regular	☐Cysto	☐OSI Jackson
Laser:	☐Yes	☐No	☐ Laser Type: _____
Cyberwand:	☐Yes	☐No	

☐ **Medical Pre-Op With:** _____ **Date:** _____ **Time:** _____
☐ **Pre-Op With Surgeon** **Date:** _____ **Time:** _____

MISC. SCHEDULING INFORMATION

_____
_____