HONORHEALTH

☐ New Case ☐ Existing Case

# Surgery Scheduling Request Form

Phone: 623-580-5800 Fax: 480-882-7874 Email: HonorHealthPeriopScheduling@honorhealth.com

***This is not a Preoperative order*** This is only a case booking request. All information in **BOLD** type is required to avoid scheduling delays.
*If you are making changes to the Location, Patient Class or CPT code please contact the patient's insurance company and update the authorization.*

**Today's Date:**_____ **Scheduler Name:**_____ **Contact Number:** _____

## PATIENT INFORMATION:

**Last Name:**_____ **First Name:**_____ **MI:**_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:** _____

**Date of Birth:**_____ SSN (if available):_____ **Sex:** ☐ Male ☐ Female

**Home Phone #:**_____ Cell Phone#_____ **Email address:**_____

## CASE INFORMATION: Location (choose one)

| | | | | | |
|---|---|---|---|---|---|
| ☐ DV IP MAIN | ☐ DV CATH | ☐ DV ENDO | ☐ JCL IP MAIN | ☐ JCL OP | ☐ JCL CATH |
| ☐ JCL ENDO | ☐ SONORAN IP OR | ☐ SONORAN CATH | ☐ OSBORN IP OR | ☐ OSBORN CATH | ☐ OSBORN ENDO |
| ☐ GREENBAUM | ☐ SHEA IP OR | ☐ SHEA CATH | ☐ SHEA ENDO | ☐ PIPER | ☐ TPK IP OR |
| ☐ TPK CATH | ☐ TPK ENDO | ☐ MV OR | ☐ MV CATH | ☐ MV ENDO | ☐ TEMPE IP OR |
| ☐ TEMPE CATH | ☐ TEMPE ENDO | | | | |

**Primary Surgeon:**_____ Assist:_____ Second Surgeon: _____

**Date of Service:**_____ **Start Time:**_____ **Procedure Length**_____

**Admission Type:** ☐ Outpatient ☐ Pre-Inpatient ☐ Short Stay Admit (23 Hour Observation) ☐Inpatient (Currently Admitted)

JCL 3rd Floor Request ☐Yes ☐ No **Length of Stay** (days)_____ Preoperative Medical Evaluation (OSBORN & JCL ONLY) ☐ Yes ☐ No

**Diagnosis:** _____

**ICD 10 code(s):**_____ **CPT code(s):** _____

**Procedure (Permit to Read):** _____

**Anesthesia Type:** ☐ General ☐ Local ☐ MAC ☐ Spinal ☐ Conscious ☐ Block ☐ None ☐ Other _____

**Anesthesia Provider**: ☐ Valley Anesthesia ☐ Camelback Anesthesia ☐ N/A ☐ Other: _____

**Special Needs Inst/Equip/Implants/Vendor:**

_____

_____

## INSURANCE INFORMATION:

**Primary Insurance Carrier Name:**_____ **Phone# (if available):** _____

Group**#/ID #/Claim #:**_____ **Date of Injury (if available):** _____

**Authorization Status:** ☐ N/A ☐ Pending ☐ Authorized (Number): _____

**Secondary Insurance Carrier Name:**_____ **Phone # (if available):** _____

Group**#/ID #/Claim #:**_____ **Date of Injury (if available):** _____

**Authorization Status:** ☐N/A ☐ Pending ☐ Authorized (Number):: _____