Bayshore Community Hospital
Member of the Meridian Health Family

OR SCHEDULING

Phone: (732) 739-5949
Fax: (732) 361-9355

Requested Surgery Date / Time:		Location: ☐ MAIN OR ☐ MINOR

PATIENT INFORMATION

Patient Name: (Last) (First) (M.I)	Date of Birth:	Scoial Security #:	Ht:	Wt:	Sex:
Home Address: (Street) (City) (State) (Zip)	Preferred Phone #:	Cell Phone #:	Alternate Phone #:		

SURGERY INFORMATION

Scheduled By:	Office Phone # / Ext:	Office Fax #:	Case Number:	Booking Office Initials:
Name of Surgeon:		Name of Assistant:		

Confirmed Surgery Date / Time:

Estimated Surgery Length:

Please be advised our schedule finalizes at 2PM the day before. Please call us if you have scheduled cases on for the following day and have not heard from us by 1:30PM.

Surgeon Block: ☐ yes ☐ no

Patient Type:
☐ Cosmetic

Inpatient:
☐ Day of Surgery Admission
☐ In House Room # _____

Outpatient:
☐ Same Day Surgery
☐ 23 Hour Stay

Anesthesia Type:
☐ Anesthesia of Choice
☐ Block:Type _____
☐ General
☐ Straight Local
☐ LMA
☐ Spinal
☐ MAC
☐ IV Sedation
☐ General / scalene
☐ Local
☐ Regional Block
☐ Other:

Diagnosis & ICD 9 Code:

Procedure & CPT Code (s)

Equipment:

Comments / Special Requests:

Has the surgery been re-scheduled ☐ yes ☐ no
Original surgery date:

Cell Saver: ☐ yes ☐ no

Latex Allergy: ☐ yes ☐ no
Need P.A.T.s: ☐ yes ☐ no
P.A.T.s performed at: ☐ Bayshore Other: _____

INSURANCE INFORMATION

Primary Insurance:			Subscriber's SSN:	Pre-Cert Required: ☐ yes ☐ no
Phone Number:	Group Number:	Policy Number:	Contact Made:	Authorization Number:
Secondary Insurance:			Implants:	
Phone Number:	Group Number:	Policy Number:		

VENDOR INFORMATION

Date Vendor contacted:	Contact name / phone number: