CATHOLIC HEALTH INITIATIVES
St. Anthony Hospital

SURGERY

SERVICE REQUISITION FORM

Fax: 541-278-3664 Phone: 541-278-2635

SURG

Patient Information

Patient Name: ____________________ SSN: ____________ DOB: ____________

Sex: ☐M ☐F Address: ____________________ City: ____________

State: ______ Zip: ____________ Phone/Contact #: ____________

Insurance Information

Patient Insured : ☐Yes ☐No Comments: ____________________

Primary Insurance: ____________ Group #: ____________ Policy #: ____________

Subscriber Name: ____________ SSN: ____________ DOB: ____________

Second Insurance: ____________ Group #: ____________ Policy #: ____________

Subscriber Name: ____________ SSN: ____________ DOB: ____________

Authorization Required: ☐Yes ☐No Authorization #(s): ____________

From [Date]: ____________ To [Date]: ____________

Physician Information

Ordering Physician Name: ____________________ Phone/Contact #: ____________

Primary Physician Name: ____________________ Phone/Contact #: ____________

Service Information

Procedure [Desc.]: ____________________

Procedure Code(s) [CPT]: ____________________

Diagnosis [Desc.]: ____________________

Diagnosis Code(s) [ICD9]: ____________________

Service Physician Name: ____________________ Requested Service Date: ____________

Requested Start Time: ____________ Total Time: ____________ Side: ☐RT ☐LT ☐BILAT

Status: ☐OPS ☐SDC/<24HR ☐AM/INPT Pre-Admit: ☐Yes ☐No Date/Time: ____________

Please Call Day Surgery (541-278-3242) to schedule a pre-op appointment.

Arrival Time to Hospital on Day of Surgery: ____________________

Anesthesia: ☐Choice ☐General ☐Spinal/Epidural ☐MAC/IVS ☐IVS ☐LOCAL

Special Requests/Equipment: ____________________