CHI 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: _____ Fully Vaccinated: □Yes □No

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

Special Requests/Equipment: _____