Tri-State Memorial Hospital & Medical Campus

SURGERY SCHEDULING FORM

Patient Name _____ Date of Birth ____/____/_____

Patient Address _____ Patient Phone # _____

Guarantor _____ Guarantor Phone # _____

Best time to call for Pre-Op Appointment _____ Procedure/Surgery Date ____/____/_____ Time _____

Was this appointment confirmed with scheduler? ❑ Yes ❑ No

Description of procedure/surgery_____

_____

Additional Information (equipment) _____

Was vendor notified? ❑ Yes ❑ No Contact Name _____ Phone # _____

Do you have history of MDRO/VRE? ❑ Yes ❑ No

Have you been tested for COVID-19? ❑ Yes ❑ No Date Tested____/____/_____ Results ❑ Positive ❑ Negative

❑ Inpatient ❑ Outpatient (extended recovery is OUTPATIENT status – patient may stay up to 23 hours)

❑ Post/Follow-up appointment Date ____/____/_____ Time _____

Procedure Code(s) _____ Diagnosis Code(s) _____

Attending Physician _____ Assistant (if available) _____

Primary Care Provider _____

Primary Insurance _____ Policy # _____ Group #_____

Insurance Phone # _____ Subscriber Name _____ Relationship _____

Has prior authorization been obtained? ❑ Yes ❑ No Date Received ____/____/_____ Authorization # _____

Number of days approved _____ Contact person at insurance company _____

Please include surgery scheduling form along with:

- **Surgical Consent**
- **Sterilization Consent (if applicable)**
- **Admitting Orders**
- **Copy of Insurance Card**

TRI-STATE SURGERY SCHEDULING

PHONE: 509.758.4661

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