Emanate Health
L&D Surgery Scheduling Form

Campus: ☐ FPH ☐ QVH

Procedure Information

*Requested Proc Date: ________ *Requested Proc Time: ________ ☐ AM ☐ PM Est Length: _________
*Surgeon: ____________________________________ Assistant: ____
*Procedure: ☐ Primary Cesarean Section ☐ Repeat Cesarean Section
☐ Other (Tubal Ligation): ____
*EDC(Due Date): _____________________ ☐ Twins ☐ Surrogacy ☐ Adoption
*High Risk: ☐ Yes ☐ No Please Explain: ____
*CPT Codes: ____
*ICD 10 Codes: ____
*Diagnosis: ____
Anesthesia Type: ☐ General ☐ MAC ☐ Epidural ☐ Spinal
*Special Considerations: *Latex Allergy:* ☐ Yes ☐ No *Sleep Apnea:* ☐ Yes ☐ No ☐ Unknown
Additional Considerations
(e.g. Transfusion-free & Isolation):

Patient Information

*Last Name: _________________________________ *First Name: ____________________________________
*Date of Birth: __________________ *Social Security Number: ____________________
*Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_________________________________
*Primary Phone Number: _______________________ Secondary Phone Number: ________________________
*Address Type: ☐ Home ☐ Long-Term Care Facility ☐ SNF ☐ Other: ______________________
*Street: ____________________________ *City: _________________________ *State: ________ *Zip: ________
*Primary Care Physician's Name: ___________________________________ *Phone: ______________________
Cardiologist (Open Heart Only): ___________________________________ Phone: ________________________

Insurance & Admission Information

*Insurance: ____ Policy Number: _________________________
Insurance ID: _______________________________________ *Authorization Number: ______________________
*Admit Type: ☐ AM Admit ☐ Inpatient Room: ________

Supply & Equipment Information

*Special Equipment Requests: ☐ N/A

Office Completion Information

*Office: _____________________ *Person Completing: ________________________ *Date: _______________
*Phone: ____________________________ *Ext: ____________ *Fax: _____________________________________

Booking Completion Information (Hospital Schedulers Only)

Scheduled Date: _______________ Scheduled Time: ________________ Surgery Case #: _______________
Medical Record #: _______________________ Account #: _______________________________