St. Francis Medical Center

3630 East Imperial Highway, Lynwood, CA 90262

Care Connect- 833-279-2337
Direct Line- 310-900-2737

☐ Inpatient
☐ Outpatient
☐ Transfer
☐ Observation

Surgical/Admission Booking Form

E-FAX: 833-442-0375 / Alternative Fax: 310-900-2774

Email: SFMC-SurgeryScheduling@primehealthcare.com

***** Please note: Incomplete Booking Forms will not be accepted. All forms must be completed and include the needed authorizations to schedule case. Case is not scheduled until you have received phone confirmation from the Scheduling team *****

PATIENT INFO ☐ DEMOGRAPHIC INFO ATTACHED **Case Type:** ☐ ELECTIVE

Patient Name:____ ☐ M ☐ F
Address:____
City:________________________________ State:__________ Zip:__________
Phone: (home)_________________________ Work/Cell:________________
DOB:____________________ Social Security #:_________________________
Email:________________________________
Pt. Conserved? ☐ YES Name/Contact Info for Conservator:___________________
Relative/Guardian Name: ____
Pt from Nursing Home/Assisted Living? ☐ YES
Nursing/Assisted Living Center:______________________ Phone:_______________
Guarantor Name:____
Pt. Relationship to Insured: ☐ Patient ☐ Spouse ☐ Dependent

SURGEON NAME:_______________________ Proc/Surg Date:__________ Time:____________
2nd SURGEON:______________________________ PAIN MD:_____________________________
Scheduled by:_____________________________ Office #:______________________________
Fax #:____________________________________ Email:_________________________________
Surgical 1st Asst. Name:______________________________________ ☐ Confirmed
Diagnosis:____ ICD 10:______________
Additional Diagnosis:____
Procedure:____
____
CPT(s):______________________________ Expected Duration for Procedure:_______________
Primary Care Physician (PCP):___________________________ Phone:____________________
Case Referred by:___________________________________Phone:____________________
POST OP Physician:_________________________________ Phone:____________________

ATTACH COPY OF OTHER REQUIRED DOCUMENTS (orders, office notes, H&P (performed within 30 days), anesthesia info, etc.

INSURANCE INFORMATION: Complete information below and/or attach copies of Insurance Cards (front & back)

Primary Insurance;____________________________
Medical Group:______________________________
Policy #:__________________________________
Insurance Group:____________________________
Claims Address:_____________________________
Insurance Phone:____________________________
Authorization #:____________________________
EMPLOYER:_________________________________

Secondary Insurance:__________________________
Medical Group:______________________________
Policy #:__________________________________
Insurance Group:____________________________
Claims Address:_____________________________
Insurance Phone:____________________________
Authorization #:____________________________
____

Workers Comp? ☐ YES Date of Injury:____________
WCI_______________________________________
Claim #:___________________________________
Adjuster:__________________________________
Ins Address:_______________________________
Ins/Adjuster Phone #:_______________________
____
____

SPECIAL EQUIPMENT NEEDS and Preferences

POSITION: ☐ Supine ☐ Prone ☐ Lithotomy ☐ Lateral
TABLE: ☐ Hana ☐ Jackson ☐ Angio ☐ ESWL
FLUOROSCOPY: ☐ X-RAY ☐ MINI-C-ARM ☐ C-ARM
OTHER: ☐ LIGASURE ☐ LASER __________ ☐ BIPOLAR (URO button)
☐ HTA (GYN ablation) ☐ TRU-CLEAR (GYN operative) ☐ LITHO
☐ NEURO MONITORING ☐ MICROSCOPE ☐ CELL SAVER
Implants: ________________________ Vendor: __________________________
Other: __________________________ Vendor: __________________________

ANESTHESIA TYPE

General	☐
MAC	☐
Local	☐
IV Sedation	☐
Block	☐
Other	☐

For assistance please contact the Surgical Scheduling Team at (310) 900-2737. Thank you for selecting St. Francis Medical Center.

SPECIAL EQUIPMENT NEEDS and Preference Sheet

Patient's Name:____ **DOB:** _______________________

POSITION: ☐ Supine ☐ Prone ☐ Lithotomy ☐ Lateral

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IMPLANTS:___________________________________ **VENDOR**: _________________________________

OTHER: ____ **VENDOR:** _________________________________

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