



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

***** 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 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? <input type="checkbox"/> YES Date of Injury: _____ WCI _____ Claim #: _____ Adjuster: _____ Ins Address: _____ Ins/Adjuster Phone #: _____
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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

Pre-Operative/Surgery Orders

Patient Name: _____ Phone: _____ DOB: _____

Pediatrician Requested: _____

Scheduled Procedure (Consent for)	Date	Time _____am/pm	Patient instructed to arrive at: _____ am/pm
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PART I: PRE-OP ORDERS Height _____ Weight _____ History and Physical Date Dictated Attached NPO Past Midnight

All lab testing per SFMC PAT clinic guidelines and/or any of the following: Laboratory to be drawn at: UniLab SFMC Other _____

CBC PT (if on Coumadin)/PTT(if taking anticoagulant _____) UA βHCG, serum

Type and Screen Type and Cross _____ units of o PRBC o Platelet

Basic Metabolic Panel Comprehensive Metabolic Panel K+ on DOS Other _____

X-Ray: Chest-PA/Lateral Pos PPD: Chest 1 View Other _____

EKG: Yes No Indication for Exam _____

PART II: ORDERS

IV Fluids _____ Rate _____ ml/hr NKDA Allergy: _____

Pre-Op Antibiotics Yes No Medication _____

Medical Clearance / Consult with _____ Date Contacted _____

Obtain Consent Bicitra 30ml PO NST

Additional Orders:

COVID-19 (within 7 days of surgery): _____ _____

Physician's Signature: _____ Date: _____ Time: _____

Nurse's Signature: _____ Date: _____ Time: _____

Patient Identification