MIAMI VALLEY HOSPITAL
SURGERY SCHEDULING

FAX 937-208-2645
PHONE 937-208-2223

Date of surgery:_____ Time:_____ Surgeon:_____

Patient Last Name:_____First:_____

Date of Birth:____/____/_____ Home Phone: (_____)_____

Social Security #:_____ Sex: M / F

Alternate Phone #: (_____)_____

Patient status: Outpatient:____ Outpatient/Observation:____ Same day:_____

Inpatient:_____ Room #:_____Admit date: (**if prior to day of surgery**)_____

Anesthesia type:_____

Procedure:_____

(cont.)_____

Equipment or any special requests: (position, c-arm, table, instrumentation, etc) _____

Amount of time needed for procedure:_____

Asst. Surgeon:_____ Primary Care Provider:_____

Primary Insurance:_____ ID #:_____

Secondary Insurance:_____ ID #:_____

Diagnosis wording: (no codes)_____

Special considerations: (latex allergy, MRSA, VRE, nursing home patient, disability, power of attorney) _____

Fax PAT orders to 937-208-5100 Fax pre-op orders to 937-208-5102