

## ENT SCHEDULING SHEET

<b>Bend</b>	<b>Redmond</b>	<b>Prineville</b>	<b>Madras</b>
Fax: 541-706-6342 Phone: 541-706-7788	Fax: 541-526-6568 Phone: 541-526-6503	Fax: 541-416-1192 Phone: 541-447-8346	Fax: 541-460-4070 Phone: 541-460-4083

### PATIENT INFORMATION

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender: Female Male Last Four Digits Of SSN: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Pt. Preferred Number: Home Cell Work Best Time To Call Pt: Morning Afternoon Evening  
 Interpreter Needed: Yes No Language: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_  
 Medicare: Yes No Authorization / Pre Certification Number: \_\_\_\_\_

### SURGERY INFORMATION

Surgery Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Assistant: \_\_\_\_\_  
 Secondary Surgeon: \_\_\_\_\_  
 Surgeon's Scheduler Name: \_\_\_\_\_ Direct Phone: \_\_\_\_\_  
 ICD(s): \_\_\_\_\_ CPT(s): \_\_\_\_\_  
 Working Diagnosis: \_\_\_\_\_  
 Procedure: Left Right Bilateral \_\_\_\_\_  
 \_\_\_\_\_  
 Inpatient / Outpatient / Current In Patient - Room #: \_\_\_\_\_ Time Required (Cut to Close): \_\_\_\_\_  
 Position For Surgery: Supine / Lateral / Lithotomy / Prone / Sitting / Other: \_\_\_\_\_  
 Approach: Laparoscopic Open  
 Anesthesia: General / Spinal / MAC / Local / Bier / Moderate Sedation / Other: \_\_\_\_\_  
 Instrumentation: \_\_\_\_\_  
 Special Order - Type: \_\_\_\_\_ Size: \_\_\_\_\_ Manufacturer: \_\_\_\_\_  
 Vendor Rep Notified: Yes No Rep Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Implant \_\_\_\_\_ Implant Authorization No. \_\_\_\_\_

Fine Needle Aspiration: Scheduled / Pre-arranged with Pathology at (541) 382-7696  
 Balloon Sinuplasty Balloon Dilation  
 Laser OmniGuide - Laser Tech to deliver instruments 24 hours prior to surgery

Neoprobe	GE 'Image Guided'	Nerve Monitor: Check one below
Mayfield	BAHA	EMG Tech Monitor Only - No Tech
Vocom	Steroid Containing Stents (Propel)	

**Medical Pre-Op With:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
**Pre-Op With Surgeon** **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

### MISC. SCHEDULING INFORMATION

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