St. Charles HEALTH SYSTEM

Today's Date : ___________

ROBOTICS SCHEDULING SHEET

Bend	Redmond	Prineville	Madras
Fax: 541-706-6342	**Fax: 541-526-6568**	**Fax: 541-416-1192**	**Fax: 541-460-4070**
Phone: 541-706-7788	**Phone: 541-526-6503**	**Phone: 541-447-8346**	**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 **Single Site: YES NO**
Robotic Assisted: ____
____
Inpatient / Outpatient / Current In Patient - Room #: ______ Time Required (Cut to Close): ______________
Position For Surgery: Supine / Lateral / Lithotomy / Prone / Sitting / Lithotomy
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.________________

Ultrasound
Surgeon Provided
Outside Vendor (see above)
Hospital Ultrasound Notified

Special Equipment
C-Arm

Medical Pre-Op With: _______________________________ **Date:** _____________ **Time:** ___________
Pre-Op With Surgeon Date: _____________ **Time:** _____________

MISC. SCHEDULING INFORMATION

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Updated On 9/21/15