THS Surgery Scheduling Booking Sheet

Facility: SELECT ONE

Patient Name: Last _____ First _____ Middle _____ Suffix _____

DOB: _____ / _____ / _____ Social Security Number: _____ - _____ - _____ Sex at Birth: SELECT ONE

Address: _____

Home Phone #: _____ - _____ - _____ Cell Phone #: _____ - _____ - _____

Admission Status after Surgery (circle one): SELECT ONE

Type of Case (circle one): ◯ Elective ◯ Priority Elective (authorization is a priority)

Surgeon: _____ Assisting Surgeon: _____

Date of Surgery: _____ / _____ / _____ Time Surgery Requested: _____ PAT Preference Date: _____

Diagnosis: _____

Procedure(s) – include Site/Side: _____

CPT Codes(s) used to Obtain Authorization: _____

ICD-10 Code(s) used to Obtain Authorization: _____

Anesthesia Type Requested (circle one): SELECT ONE OTHER _____

LATEX ALLERGY (needs to be 1st case of day): SELECT ON Other Allergies: _____

Imaging Needed During Case: SELECT ON Type: _____ Pathologist Needed During Case: SELECT ONE

Visual Acuity/Function for Cataract Procedures: SELECT ONE Medicaid Sterilization Form: SELECT ONE

Special Tools/Equipment for Case: _____

Required H&P Attached for Dental, Pediatric and Podiatry Cases ◯ YES ◯ NA

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Physician Authorization: _____ or NPR _____ Valid Dates for Procedure: _____

Facility Authorization: _____ Valid Dates for Procedure: _____
(required if < 72 business hours before case)

Physician Signature: _____ Date/Time: _____

Facility NPI: SFH - 1891732889 TMH – 1316925506

Fax to Appropriate Surgical Area:

TMH Ambulatory:	**304-414-2720**	**STF Endo/Minor:**	**304-414-4941**
TMH Endo/Minor:	**304-414-2719**	**STF ODSC:**	**304-347-6297**
TMH Main OR:	**304-766-4451**	**STF Main OR:**	**304-347-6894**

OP0280

Thomas Health

USE LABEL OR PRINT PATIENT ID HERE