First Hill
SURGERY CENTER

1101 Madison St., Suite 200 • Seattle, WA 98104-1306

FAX: **206-860-2292** Phone: **206-320-6677** Date & Time Faxed:

Requested Surgical Date: Case Classification: ☐ Block ☐ Non-Block

Patient's Name: MRN:
Last, First, MI

DOB: Gender: ☐ Male ☐ Female

Best Phone Number to Call: Ok to Leave Message? ☐ Yes / ☐ No

Parent or Guardian Name if applicable:

Surgeon's Name: Co-Surgeon's Name: Assistant's Name:

If applicable, Breast Center, Location: Time:

If applicable, Nuc Med, Location: Time:

Insurance Company:

Preauthorization Required? ☐ Yes / ☐ No; ☐ Not Required / ☐ Urgent / ☐ Emergent / ☐ Other

If Yes, Status: ☐ Pending; requested on:

☐ Approved; Authorization # Method Auth Obtained/Verified Unnecessary:

☐ **See Epic referral.** ☐ **No Epic referral, see below.**

Patient Class: ☐ Ambulatory ☐ Ambulatory Overnight

ICD-10 Code(s): Side: ☐ Left ☐ Right ☐ Bilateral

Pre-Op Diagnosis Name:

CPT code(s):

Procedure Name:

Equipment/Implants/Comments:

Anesthesia Type: ☐ Block ☐ Spinal ☐ Choice ☐ Gen ☐ MAC ☐ Pediatric ☐ Local Only

Pain pumps must be pre-ordered ☐ Comments

Length of Procedure: Minutes

Imaging: ☐ No / ☐ C-Arm / ☐ Mini C-arm Nuc Med: ☐ No

Lab Required: ☐ No / ☐ EKG / ☐ HCT / ☐ Potassium / ☐ Pregnancy Test / ☐ Other

Anesthesia Review Required: ☐ Yes / ☐ No If Yes, Why?:

Interpreter: ☐ Yes ☐ No If yes what Language:

Attachments Required: Demographic Face Sheet, Insurance card, Copy of Authorization (when approved)

Physician Office Info

Office Scheduler: Name of Office:

Office Phone: Office Fax: