Surgery Posting Form

Houston Northwest MEDICAL CENTER

FAX TO 281.440.2411

Please note that all information must be complete in order to process your request efficiently. Thank you!

DOCTOR INFORMATION

Dr. _____

Requested by _____

Contact telephone _____

Fax (send confimation here) _____

PATIENT INFORMATION

Please fax office demographic form or complete below.

Name _____

Address _____

Date of birth_____

Social security number_____

Home telephone _____

Work or cell _____

INSURANCE INFORMATION

Carrier _____

Insured _____

Insured date of birth_____

Policy number _____

Group number _____

Benefit telephone _____

Relationship of insured to patient _____

If minor: minor date of birth _____

Minor parent name _____

Claim mailing address _____

_____

Secondary insurance information

_____

_____

STAFF ALERTS

Contaminated	◯ Yes	◯ No
MRSA	◯ Yes	◯ No
C-ARM	◯ Yes	◯ No
Frozen section needed	◯ Yes	◯ No
Latex allergy	◯ Yes	◯ No
Other	◯ Yes	◯ No

DIAGNOSIS

_____

_____

_____

PROCEDURE INFORMATION

_____

_____

_____

Procedure date _____

Requested procedure start time _____ Room _____

Next opening ◯ Yes ◯ No ◯ Inpatient ◯ Outpatient

Estimated length of procedure _____

Desired date/time for pre-op appointment in ACC:

Date _____ Time _____

Additional equipment and requests for procedure _____

_____

_____

_____

ANESTHESIA INFORMATION

Anesthesia type expected:

◯ **Ancillary block**

◯ **Scalene block** ☐ Epdural ☐ Local MAC

◯ **Bier block** ☐ General ☐ Spinal

◯ **Cons sedation** ☐ Local ☐ Local standby ☐ Local and IV sedation

◯ **Topical**

◯ **TIVA**

Other anesthesia related info _____

_____

Assisting physician _____

FOR HOSPITAL USE ONLY

Time fax received _____

Confirmation number _____

Fax received by_____

Fax confirmation by _____