Form No. 348 9/2017

BOYS TOWN National Research Hospital

ABR SCHEDULING FORM

Referring Provider: _____

Office phone number: _____Office contact person: _____BT Scheduler: _____

Patient name: _____ DOB:_____ ☐ Male ☐ Female

Address: _____

Parents/Legal guardian: _____ Relationship to patient: _____

Phone Numbers: Home _____ Work _____ Mobile _____

Diagnosis: _____

_____

Procedure: Auditory Brainstem Response Testing (ABR) under general anesthesia, possible ear mold impressions

Admission type: ☐ Same Day Surgery ☐ EAST ☐ WEST

Preferred language for healthcare: _____ Interpreter (including sign) needed: ☐ Yes ☐ No

History & Physical to be completed by: ☐ PCP Name _____Phone:_____

Specific patient, procedure or treatment needs: _____

_____

Insurance Coverage (please fax copy of card): _____

Employer: _____

Policy Holder: _____ Policy #_____ Group #_____

Benefits & Eligibility Phone #_____

Initiate orders per ABR preferences

Initiate anesthesia protocol (Anesthesiology will obtain informed consent for the anesthesia)

Physician Signature _____ Date _____ Time _____

EMAIL COMPLETED SHEET TO surgery.scheduling@boystown.org or FAX: 402-758-7778 QUESTIONS, CALL: 402-758-7777