(Patient Label)

BOYS TOWN®
Saving Children Healing Families
BOYS TOWN NATIONAL RESEARCH HOSPITAL

ABR SCHEDULING FORM

Referring MD: _____

Office phone number: _____ **Office contact person:** _____ **BT Scheduler** _____

Patient name: _____ **DOB:** _____ ❑ Male ❑ Female

Address: _____

Phone numbers: Home: _____ **Work:** _____ **Cell:** _____

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

Diagnosis: _____

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 #: _____

Please check the following boxes to indicate compliance with regulatory requirements:

❑ Provided sufficient information so that patient and/or guardian understand:
- The nature of his/her condition
- The purpose of the proposed procedure or treatment
- The risks, benefits, consequences and the probability of success of the proposed procedure or treatment
- The alternatives
- The prognosis if the procedure is not performed or any treatment given

❑ Initiate orders per ABR preferences
❑ Initiate anesthesia protocol

_____ _____

Physician Signature ***Date/Time***

FAX COMPLETED SHEET TO 402-758-7778

QUESTIONS PLEASE CALL 402-758-7777