(Patient Label)

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

SURGERY SCHEDULING FORM

SURGERY DATE: _____ **SURGERY TIME:** _____ **SURGEON:** _____

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

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

Address: _____ **Parent/Legal Guardian:** _____

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

Procedure: _____

_____

Diagnosis: _____

Length of case: _____ ❑ EAST ❑ WEST **Date of last office visit:** _____

Preferred language for healthcare: _____ **Interpreter needed: ❑ Yes ❑ No**

History & Physical to be completed by: ❑ Surgeon ❑ PCP – Name: _____ **Phone:** _____

Admission type: ❑ Outpatient ❑ Inpatient (Pre-authorization required) Authorization #: _____

Specific patient, procedure or treatment needs: _____

_____

❑ **KUB needed (for Urology Cases only)** ❑ U/S, X-Ray reports. Where were tests done?

Insurance Coverage (please fax copy of card): _____

Employer _____

Policy Holder: _____ **Policy #:** _____ **Group #:** _____

Benefits & Eligibility Phone #: _____

❑ 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 my pre-op preferences
❑ Initiate anesthesia protocol

_____ _____

Physician Signature ***Date/Time***

FAX COMPLETED SHEET TO 402-758-7778

QUESTIONS PLEASE CALL 402-758-7777