BAYLOR SCOTT & WHITE MEDICAL CENTER −FRISCO
SURGERY REQUEST/PHYSICIAN ORDERS
FAX: 214 − 407 − 5125

Patient Name *(As it appears on Driver's License):* _____

Patient Social Security #: _____

Pre−Op Diagnosis: _____

Surgeon: _____ Date of Procedure: _____ Time of Procedure: _____

ANTICIPATED PATIENT STATUS: *Questions regarding patient status? Please contact Case Manager at 214−407−5661*

(Note: The patient status listed on the physician's orders is the official status used for billing purposes.)
Please select appropriate patient status below.

☐ **INPATIENT:** Person who is to be formally admitted to a hospital for a surgical procedure, and who is expected to stay postoperatively more than 24 to 48 hours.

☐ **OP/Same Day Case:** Person scheduled for **same day surgical care** whose care will not exceed **23 hours 59 minutes**. Medical Necessity for change of patient status must be documented in the medical record.

Procedure to be Performed: _____

_____

CPT Code: _____

ICD10 Code: Est. OR Time: Length of Procedure:

Day of surgery, upon arrival, please:

☐ IV Fluids: Lactated Ringers at KVO started with buffered lidocaine on admission.
☐ Blood sugar on admission for diabetic patients.
☐ Pregnancy test on admission for women of child bearing age.

Frozen Section Requested: ☐ YES ☐ NO Grafts/Tissue Requested: ☐ YES ☐ NO

Specifications for Grafts/Tissue (Size/Width/Length) _____

_____

Special Needs/Requests: (Include Instruments to be Delivered/Vendor Name/Phone#): _____

_____

Anesthesiologist: _____ Block needed: ☐YES ☐NO Type: _____

MD Signature: Date:

Patient Information Date of Birth: _____ Age: _____ Gender: ☐M ☐F

Patient Address: _____City_____State_____ Zip _____

E−Mail Address: _____

Home Phone #: _____ Work Phone #: _____Cell # or Other:_____

Has patient been to BS&WMCF before?: ☐ YES ☐ NO Date of injury: _____

Policy Holder Information

Name: _____ Date of Birth: _____

SSN #:_____PreCert/Authorization #:_____

Insurance Name: _____ Phone #: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Subscriber Name: _____ Subscriber DOB #: _____

Person Providing Info:_____Scheduler Initials:_____

Physician Office Contact Name/Phone Number:_____