BAYLOR SCOTT & WHITE MEDICAL CENTER − FRISCO
OB SCHEDULING REQUEST / PHYSICIAN ORDERS
FOR TERM OR POST DATE DELIVERIES
PHONE: 214− 407− 5656 / FAX: 214− 407− 5657

Patient Name: ____________________

Pre−Op Diagnosis: ____________________ Requested Date: __________

Ordering Physician: ____________________ Requested Time: __________

Anesthesia Needed: ☐ YES ☐ NO

Initiate Admission Orders: ☐

PATIENT STATUS:

☐ **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.

PROCEDURE TO BE PERFORMED:

☐ Cesarean Section ☐ Elective Inducation Include, **CERVIDIL** ☐ Medical Induction **(not prior to 39 weeks)** **CYTOTEC** ☐

ICD−10 Code &: ____________________

WRITTEN DESCRIPTION (both must be included) ____________________

____

EDD: __________ Last Menstrual Cycle: __________ G: ______ P: ______

Special Needs/Requests: ____________________

Physician Signature ____________________ **Date** ______ **Time** ______

A PATIENT DEMOGRAPHICS PAGE WITH THE BELOW INFORMATION INCLUDED MAY BE SENT			
PATIENT INFORMATION:			
Date of Birth:	Age:		SS#:
Patient Address:			
City:	State:	Zip	Phone #:
Email Address:			
INSURANCE POLICY HOLDER INFORMATION:			
Insured's Name:		Birth Date:	SS#:
Insurance:			
Policy #:		Group #:	

Physician Office Contact Name/Phone Number: ____________________

PATIENT MUST BE PRE−REGISTERED AND PRENATALS MUST BE SENT FOR REQUEST TO BE CONFIRMED