Anne Arundel Medical Center
Annapolis, MD 21401

# Scheduling Request for Procedures

**AAMC Central Scheduling Office**
Phone: 443-481-1500 • Fax: 443-481-1515

☐ Revision Date _____

| | | |
|---|---|---|
| PATIENT NAME *(Please Print)* | | |
| SOCIAL SECURITY | DATE OF BIRTH | |
| HOME PHONE # | WORK PHONE # | CELL PHONE # |
| INSURANCE CO NAME | E-MAIL | |
| POLICY # | GROUP # | |
| AUTHORIZATION # | SUBSCRIBERS NAME | |
| PRE-CERT ICD-9 CODE | | |
| PRE-CERT CPT CODES | | |

**Primary Care Physician / Licensed Independent Provider:** _____

Latex Allergy? ☐ Yes ☑ No

**Sex:** ☑ Male ☐ Female **Height** _____ **Weight** _____

1. **Patient Status:** ☐ Inpatient / SDA ☑ Outpatient
2. **Admit to the service** of **Benjamin Petre, MD** Assist / 2nd Surgeon _____ ☑ RNFA

   ☐ Hospital Pavilion - Same Day Admission
   ☐ Hospital Pavilion - Day Before Admit
   ☐ Critical Care Bed Post-Op
   ☐ Clatanoff Pavilion Same Day Admission
   ☑ Hospital Pavilion - Ambulatory
   ☐ ESP Same Day Admission
   ☐ ESP Ambulatory
3. **Procedure date** requested _____ Time _____ , 2nd Choice Date _____ Time _____

   Time Needed **per History** _____ Minutes*** (setup & teardown time will be added)***

   Comments: *(obese, difficult case, revision, nursing home patient)* _____
4. **Diagnosis:** _____
5. **Schedule for:** *(No abbreviations accepted)* _____

   _____

   ☐ Procedure is on Research Protocol No. _____
6. **Special Equipment / Needs:** _____

   _____

   ☐ Specialty Bed
7. ☐ **Potential for High Blood Loss**
8. **Planned Anesthesia:** ☑ General ☐ Spinal ☐ MAC ☐ Epidural ☐ Local ☐ Choice
9. **Post Op Need:** Critical Care Post Op: ☐ Telemetry
10. **Patient History:** *(Check ALL that apply)* ☐ Pacemaker / Defib ☐ Diabetes
11. ☐ Pre-Anesthesia Testing Center (P.A.T.) ☐ Anesthesia Consult _____

**Requestor:** _____ **Benjamin Petre, MD** _____ **Date** _____ **Time** _____

**FOR SCHEDULING USE ONLY.**
**NOT PART OF THE LEGAL MEDICAL RECORD.**

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REV. 3/25/11