



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 <i>(Please Print)</i>		
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** _____ **Assist / 2nd Surgeon** _____ RNFA

- | | |
|---|---|
| <input type="checkbox"/> Hospital Pavilion - Same Day Admission | <input type="checkbox"/> Hospital Pavilion - Ambulatory |
| <input type="checkbox"/> Hospital Pavilion - Day Before Admit | <input type="checkbox"/> ESP Same Day Admission |
| <input type="checkbox"/> Critical Care Bed Post-Op | <input type="checkbox"/> ESP Ambulatory |
| <input type="checkbox"/> Clatanoff Pavilion Same Day Admission | |

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: _____ **Date** _____ **Time** _____

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



5 5 6 2 9