

**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: _____ ICD-9 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 #: _____

Insurance Address: _____ City _____ State _____ Zip _____

Person Providing Info: _____ Scheduler Initials: _____

Physician Office Contact Name/Phone Number: _____

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Surgery Request / Physician Orders



SCHORDER

(Rev. 09/16/15)