Reset Form

Mount Sinai

Mount Sinai Health System OR Booking Request Form

☐ MS Brooklyn ☐ MS Petrie ☐ MS Chelsea ☐ MS Union Sq ☐ MSH ☐ MSQ ☐ NYEE ☐ MSSL ☐ MS West

REQUIRED: ASA Class: ☐ 1 ☐ 2 ☐ 3 ☐ 4 BMI: _____ Ht _____ Wt _____ Post Op-ICU reservation: ☐ Yes ☐ No
Anticipated EBL >500cc ☐ Yes ☐ No

SCHEDULED BY:		PHONE/E-MAIL:	
SURGEON NAME (S):		CANCEL ☐ Reason:	
ASST. SURGEON(S):		UPDATE ☐ Item(s):	
NEW PROCEDURE DATE: / /		TIME REQUESTED: _____ : _____	TIME REQUIRED: ____ hrs ____ mins *(Not including turnaround; 30-min added for most cases)*
ORIGINAL PROCEDURE DATE: / /			

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I:	PREF NAME:
GENDER: ☐ M ☐ F D.O.B: / /	S.S.#:	MRN:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME/CELL #:	WORK #: EXT:	EMAIL:	

DIAGNOSIS & ICD-10 CODE (Including exact Side/Side/Level)

Diagnosis/ICD Code:	# WEEKS GESTATION:
Diagnosis/ICD Code:	
Diagnosis/ICD Code:	

PROCEDURE & CPT CODES (Use exact wording of procedure including Site/Side/Level)

PROCEDURE 1:	CPT:
PROCEDURE 2:	CPT:
PROCEDURE 3:	CPT:
PROCEDURE 4:	CPT:
PROCEDURE 5:	CPT:

CATHETER TYPE: ☐ Perma-Catheter ☐ Hickman ☐ Peritoneal Shunt ☐ Hemodialysis ☐ Other:

MONITORING: ☐ SSEP ☐ EMG ☐ MEP ☐ SNAP ☐ SPHINCTER ☐ BLOOD MANAGEMENT (IF APPLICABLE)

EQUIPMENT: ☐ JACKSON TABLE ☐ WILSON FRAME ☐ FLUORO ☐ MICROSCOPE ☐ LASER: ☐ CELL SAVER ☐ SPIDER POSITIONER ☐ FEMTO ☐ PREMIUM LENS

SPECIAL INSTRUMENTS OR EQUIPMENT/INSTRUCTIONS:

INTERVENTION INFORMATION

☐ AMB ☐ SDA ☐ IP - ADMIT DATE: LENGTH OF STAY: ☐ Semi ☐ PVT ☐ Luxury ☐ POST OP PAIN MGMT

ANESTHESIA: INTERPRETER: ☐ Yes - Language: ☐ Pacemaker ☐ ICD Type:

HISTORY: ☐ MRSA ☐ VRE ☐ CRE ☐ C. AURIS ☐ TB ☐ Other ALLERGIES: ☐ Latex ☐ Other:

INSURANCE INFORMATION AND CONTACT NUMBERS

INSURANCE 1:	POLICY #:		POLICY HOLDER:	
GROUP #:	AUTH #:		RELATION TO PT:	
ADDRESS:	CITY:	STATE:	ZIP:	PHONE:
INSURANCE 2:	POLICY #:		POLICY HOLDER:	
GROUP #:	AUTH #:		RELATION TO PT:	
ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

GUARANTOR INFORMATION (Parent/Guardian)

LAST: FIRST: RELATION TO PT: D.O.B: / /

PRESURGICAL TESTING BY HOSPITAL (Unless under special arrangement, below same as surgery site)

DATE TIME ____:____ ☐ AM ☐ PM ☐ MSH ☐ MS West ☐ MS Union Sq ☐ NYEE ☐ Other: