HALIFAX HEALTH

PRE−OP AND OPERATIVE SCHEDULING

HHMC Phone: (386) 254−4148 ***or Fax:*** (386)252−0092
TLSC Phone: (386) 274−1665 ***or Fax:*** (386)274−2070

OR SCHEDULING REQUEST:

Book at: ❑ Main OR ❑ HPC ❑ HPO ❑ CVOR ❑ Endovascular ❑ HMC GI ❑ HMC OB ❑ Twin Lakes ❑ Cath Lab

Date of Surgery:_____ Time:_____

SSN:_____ Name:_____

DOB:_____ Surgeon: _____

Address:_____ Phone:_____

Insurance: Primary/#:_____ Secondary/#:_____

Diagnosis:_____ CPT Code:_____

Length:_____

Planned Procedure: _____

_____

_____

Equipment:

❑ Brain Lab	❑ C−Arm	❑ 3080 Table	❑ Allograft	❑ Robot	❑ Supine
❑ Neuro monitoring	❑ Concentric C−Arm	❑ 3085 Table	❑ Bank Bone	❑ Harmonic	❑ Prone
❑ Mayfield Headrest	❑ Pentero Microscope	❑ Jackson	❑ Autograft	❑ Video/HD Cam	❑ Lateral
❑ Horseshoe Headrest	❑ Fiber Optic Intubation	❑ ProFx	❑ Plates	❑ Morcellator	❑ Lithotomy
❑ LSO Brace	❑ Navigator	❑ Fx Table	❑ Cage	❑ Novasure	
❑ Philadelphia Collar	❑ Angio/Injector	❑ Hana	❑ Pedicle Screws		

Special Requests/Notes:_____

_____

_____

Patient Type: ❑ AM Admit ❑ SDS ❑ Inpatient Radiology Studies:_____

Anesthesia:_____

PRE−OP TESTING REQUEST: Location: ❑ HPC ❑ HPO

Visit Type: ❑ On Site ❑ RN Consult ❑ Total Joint ❑ Hysterectomy/Sterilization ❑ Open Heart

Date:_____ Time:_____

PLEASE NOTE: IF CASE IS FOR NEXT DAY, PLEASE CALL O.R. SCHEDULING TO ENSURE BOOKING

Office Scheduler requesting:_____ Email or Fax back to:_____

Date Submitted:_____

OR Case Confirmation #:_____ **Pre−op Testing Confirmation:** ❑ Yes
❑ No − (please request new date/time)