☐ ORH Oakland Regional Hospital 248.423.5159 FAX 248.281.1960
☐ ORMC Oakland Regional Macomb Center 248.423.5159 FAX 248.281.1960

SURGICAL BOARDING AND ADMISSION INFORMATION (Revision 3/22/17)

DOCTOR: _____

OFFICE LOCATION: _____

OFFICE CONTACT: _____

CONTACT NUMBER: _____

ALLERGIES:

☐ OUTPATIENT
☐ ADMISSION
☐ POSSIBLE OBSERVATION

ADMISSION REQUESTS *MUST* BE INCLUDED IN THE AUTHORIZATIONS

SURGERY REQUIREMENT ≥ 13 YEARS OLD AND ≥ 90 LBS

ADMISSION REQUIREMENT > 17 YEARS OLD

☐ THIS PATIENT RESIDES IN A SKILLED NURSING FACILITY

REQUESTED DATE OF SURGERY: _____

LENGTH OF PROCEDURE: _____

NAME: _____

SOCIAL SECURITY #: _____

DOB: _____ AGE: _____

☐ MALE ☐ FEMALE

HOME PHONE: _____

ALTERNATE PHONE: _____

ADDRESS: _____

_____

_____

ANESTHESIA: ☐ GENERAL ☐ LOCAL ☐ LOCAL/GENERAL ☐ LOCAL/SEDATION ☐ BLOCK ☐ CHOICE

POST-OP PAIN MANAGEMENT: ☐ SINGLE SHOT ☐ CATHETER PLACEMENT

PATIENT POSITION: ☐ PRONE ☐ SUPINE ☐ LATERAL ☐ OTHER

DIAGNOSIS WITH ICD10 CODE:

_____

_____

PROCEDURE WITH CPT CODE(S):

_____

_____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Subscriber:	Subscriber:
Employer: Adjustor:	Employer: Adjustor:
Adjustor Phone:	Adjustor Phone:
DOB:	DOB:
SS#:	SS#:
Policy #:	Policy #:
Group #:	Group #:
Phone # (for verification):	Phone # (for verification):
Date of injury:	Date of injury:
Authorization #:	Authorization #:

SPECIAL EQUIPMENT

PROSTHETIC/ IMPLANT REQUESTED BY SURGEON: _____

H & P CONSULT NEEDED: ☐ YES ☐ NO

SPECIAL/ OTHER EQUIPMENT: _____

FOR ORH STAFF ONLY: EQUIPMENT ORDERED: ☐ YES ☐ NO DATE ORDERED: _____ INITIALS: _____