TODAY's DATE: _____

Patient Information (Required for Scheduling)

Patient Name:_____ DOB: _____ Sex: M F SS#: _____- ____-_____
Last, First Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product
If Commercial or Workers Comp, provide address:_____

Secondary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product
If Commercial or Workers Comp, provide address: _____

Order Information - Surgery

Location: N. Decatur _____ Hillandale _____ SIS Confirmation #: _____
Date of Procedure:_____ Time: _____ Length:_____ Nuclear Med prior to surgery/time: _____
Needle Localization prior to sx/time:_____

Do you have other cases scheduled on this day? YES NO
If Yes, do you wish to change schedule order? YES NO
If Yes, please list patients by name in order: _____
Surgeon: _____ Proctor: _____ Assistant: _____
Procedure: _____
CPT Codes: _____
Case Comments/Equipment: _____
Implants needed:_____
Vendor Name:_____ Vendor contacted (D/T):_____
Diagnosis: _____
ICD CM Codes: _____
Anesthesia Type: ❑ General ❑ MAC ❑ Local ❑ Spinal
NERVE BLOCKS: ❑ Surgical ❑ Post op pain control ❑ Axillary ❑ Interscalene
❑ Adductor canal ❑ Popliteal ❑ TAP ❑ PEC ❑ Other: _____
Type of Admission: ❑ Inpatient (Medicare IP only) ❑ Inpatient (w/PreCert) ❑ Outpatient
Person Requesting Scheduling:_____ Date Faxed: _____
Confirmation Date: _____ Pre-Screen Appointment: _____
If Ophthalmology Patient: Diabetic: Yes No Natural Lens: Yes No

Referring Physician Information

Physician Name (first & last): _____ NPI#:_____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #:_____

I herby certify that the services in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time:_____

EMORY HEALTHCARE

FAX Orders to: 404.501.1874
Phone: 404.501.5590
Ext 1 - Surgeons only, Ext 2 - Scheduling

SURGERY ORDER FORM

P S - 1 0 5 9

DMC FORM # PS-1059 (03/27/17)