POSC SCHEDULING FORM

Patient Information:

NAME: Last_____ **First:** _____**MI:**_____

Contact Numbers: _____ **DOB:** _____/_____/_____

E-mail Address: _____@_____

Procedure Information:

DATE: ____/_____/_____

Anesthesia consult: **Yes** ☐ **Lab Tests Yes** ☐ **DM: Yes** ☐

Pain Management block request? ☐ **None** **Single Shot** ☐ **Catheter** ☐

SURGERY: _____

POSITION: _____

CPT CODE: 1) _____**2)** _____**3)** _____**4)** _____ **5)** _____

DX/ICD10: 1) _____ **2)** _____ **3)** _____ **4)** _____

EQUIP REQ: _____

_____

SURGEON SIGNATURE: _____

Referring Physician: _____

PRE-OPERATIVE APPT: **Date:**_____/_____/_____

Antibiotics Needed: **Ancef** ☐

Vanco ☐ **None** ☐

Special Notes:

Pend Oreille Surgery Center, llc
30544 Hwy 200, Suite 201
Ponderay, ID 83852
Fax to 208 265-4870

Date / Faxed by:_____/_____/_____

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