Rhode Island Hospital
*A Lifespan Partner*

# Surgical Services
# Booking Office

**PATIENT DATA:**

Name: Gender: M ◯ F ◯ Date of Birth: Age: Social Security:

Patient Address: City: State: Zip:

Home Phone: Work Phone: Other Phone:

**SURGICAL INFORMATION:**

Surgery Date: Estimated Time of Procedure: Case No.:

Surgeon: _____ Office Phone: Fax:

Send Confirmation Email to:

Diagnosis: ICD#

Procedure: Side: RT: ◯ LEFT: ◯ BILATERAL: ◯ N/A: ◯

Comments:

**EQUIPMENT**:

Radiology: Choose One Table: Choose One Other:

Implants: Miscellaneous:

**ANESTHESIA:**

Type: Choose One Position: Choose One Other:

Cell-Saver: Yes ◯ No ◯ Miscellaneous:

**SPECIAL PRECAUTIONS:**

Latex Allergy: Yes ◯ No ◯ Other:

**ADMISSION DATA**:

Type of Admission: Choose One Site of Admission: Choose One

PCP:

Admission Date: Admission Time: Inpatient Level of Care Needed:

ICU ◯ Intermediate ◯ Floor ◯

Presurgical Evaluation: Yes ◯ No ◯ Date: POP Tour: Yes ◯ No ◯ Date:

**INSURANCE INFORMATION:**

Primary Insurance: Choose One Secondary Insurance:

Primary Insurance Subscriber: Policy # Phone:

Secondary Insurance Subscriber: Policy # Phone:

Workers' Compensation:

Employer: Phone: Date of injury:

Address:

Insurance Company: Phone:

Address: