Sound Surgeons Surgery Scheduling Sheet

Requested surgery date and time: _____

Patient Information:

Patient name: _____Date of Birth:_____Gender: ☐ M ☐F

Last *First* *M.I.*

Primary phone: _____ Alt phone: _____

Patient Height:_____ Patient Weight:_____Patient BMI:_____

Allergies: _____

Does the patient have a latex allergy: ☐ Y ☐ N

Procedure Information:

Surgeon: _____ Does this procedure require an assist? ☐Y ☐N

Pre-operative diagnosis: _____

Procedure: _____

Procedure length (cut to close)*: _____

Special requests: (special equipment, products, implants, positioning, etc.)

_____

Misc. Surgical comments: _____

Additional Information:

Overnight Stay Needed? ☐Y ☐N Interpreter needed? ☐Y ☐ N language: _____

Diabetic? ☐ Y ☐N If DM, Last A1C:_____ Sleep Apnea? ☐Y ☐N CPAP? ☐Y ☐N

History and Physical complete & attached (*must be included to finalize surgery schedule*) ☐Y ☐N

Special equipment requests:_____

Form completed by:_____Direct Phone:_____

INTERNAL USE:

Date Requested:	Date Scheduled*:
Time Block Provided*:	Confirmed with Requestor? ☐Y ☐N
Name of Scheduler:	Date Request Completed:

*__Please Note__: Block times will be assigned base on procedure length from cut to close, and the average room turnover time appropriate for each case. If your requested surgical date is in conflict, you will be contacted immediately by our office.

PLEASE FAX TO: 425-224-8299

Please submit form a minimum of 14 days prior to requested surgical date