Capital Surgery Center

Capital Surgery Centers Boarding Form

Physician: _____ Todays Date: _____

Patient Information:

Name: _____ Height:_____ Weight_____
Address: _____
Home #: _____ Work #: _____ Cell #: _____

Gender: Male ____ Female ____ Social Security #: _____ DOB: _____

Procedure Information:

Date of Surgery: _____ Time: _____ Length: _____ (Hours)

Procedure CPT Codes: _____ _____ _____ _____ _____ _____

Procedure Description (as will be listed on the consent):

_____

_____

ICD 10 Code(s): _____ _____ _____ _____ _____ _____

Diagnosis: _____

Anesthesia: General/ MAC/ IV Sedation/ Local Assistant: Y/N Latex Allergy: Y/N

Special Requests: _____

_____

Additional Comments: _____

Insurance Information:

Primary Company Name: _____
Adjuster Name: _____ Adjustor Phone: _____
Claim #: _____ Date of Injury: _____

Contact Approval or Attorney Information:

Attorney Name: _____ Attorney Phone #: _____
Attorney Address : _____

Pre-op Lab Work (Please circle): H&P CXR EKG Cardiac Clearance CBC HCG UA Other: _____