

  
**BOOKING FORM**

**TODAY'S DATE:** \_\_\_\_\_ **Prepared by:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

ADMISSION TYPE:  ASU  23 Hour ASU  AM Admit  Endo  Spec./Rad.  Ped ASU

LATEX ALLERGY  NO  YES

**PATIENT NAME (PLEASE PRINT):** \_\_\_\_\_  
Last First

**ADDRESS:** \_\_\_\_\_

**SEX:**  Male  Female **AGE:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Primary Contact Number:** (\_\_\_\_) \_\_\_\_\_ **Alternate Contact Number:**(\_\_\_\_) \_\_\_\_\_

**INSURANCE:** \_\_\_\_\_ **SELF PAY:**  NO  YES

**SURGEON:** \_\_\_\_\_ **ASSISTANT:** \_\_\_\_\_

**DATE OF SURGERY:** \_\_\_\_\_ **REQUESTED TIME:** \_\_\_\_\_

**ALTERNATE DATE:** \_\_\_\_\_ **ALTERNATE TIME:** \_\_\_\_\_

**PROCEDURE CODE:** \_\_\_\_\_ **PROCEDURE:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_ **DIAGNOSIS CODE:** \_\_\_\_\_

**EST. OR TIME:** \_\_\_\_\_ **ANESTH TYPE:** \_\_\_\_\_ **Anesthesiologist Req:** \_\_\_\_\_

**CELLSAVER:** \_\_\_ YES \_\_\_ NO **IMAGE:** \_\_\_ YES \_\_\_ NO

**SPECIAL NEEDS:** \_\_\_\_\_

**PST Reservation Request:** (Please complete the Pre-Procedure Testing Order Form)

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_ AM \_\_\_ PM

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_ AM \_\_\_ PM

(Alternate)

**Please fax to Huntington Hospital Booking Office @ 351-2696**

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**CONFIRMATIONS:**

**SURGERY: DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**PST: DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Confirmed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_