



WENTWORTH SURGERY CENTER, LLC

New Request	
Changed Form	
Cancellation/Reason	

**SURGICAL/PROCEDURE BOOKING FORM (PLEASE TYPE)**

Person Submitting Booking: \_\_\_\_\_

Date: \_\_\_\_\_

<b>PATIENT</b>	
<b>LEGAL NAME: LAST</b> _____	<b>FIRST</b> _____ <b>MIDDLE</b> _____
Date of Birth: _____	M _____ F _____ PCP: _____
Phone(Home): _____	(Work): _____ (Cell): _____
Minor/Guardian Name: _____	
Height: _____	Weight: _____
<b>Allergies and Precautions:</b>	
Latex Allergies: Yes _____ No _____	
Diabetic: Insulin Dependent _____	Non-Insulin Dependent: _____ Sleep Apnea: _____
Hx of MH: MH++ _____ PT _____	Family _____
Other Allergies: _____	
Other Special Precautions: _____	
Procedure Date: _____	Procedure Time w/ Turnover: _____
Pre-op Diagnosis: _____	
Procedure(s): _____	CPT Code: _____
_____	_____
_____	_____
_____	_____
<b>Pre-Cert Authorization #:</b> _____	
<b>Implants:</b>	
Surgeon(s): _____	Assist Surgeon: _____
_____	_____
If two procedures, are the surgeons working at the same time? Yes _____ No _____	
If No, what time will the 2nd surgeon enter the case? _____	
Anesthesia: MAC _____	Block _____ Local _____ General _____
Equipment Needed: C-Arm _____	
Other Special Requests/Equipment Needed: _____	
Pre-Op Physical Appointment Set: _____ Date: _____ Time: _____	
Airway Evaluation: _____ Phone Call: _____	
NPO _____	CHEST X-RAY _____ EKG _____ CBC _____ CHEM _____ K+ _____ OTHER _____
Please send the completed Booking Form / Clear Copy of Insurance Card, Front & Back / Demographic Sheet - Fax to: 603-740-4639	