OR Scheduling Form

Today's Date: / /

WRITE LEGIBLY AND DO NOT USE ABBREVIATIONS

Patient First Name: ____________________ Last Name: ____________________

#1 Identifier: ____________________ #2 Identifier: ____________________

Surgeon Name: ____________________ Date of Surgery: ____________________

- *Document exact description of the entire procedure including secondary procedures, if applicable:*

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- *Document exact site, level, digit:* ____________________
- *Document correct side/laterality (circle one):*

  Right / Left

- *Name of implant, if applicable:* ____________________
- *Special equipment needed:* ____________________
- *Scheduling information provided from the surgeon's office must be verified by the assigned staff. Please check the appropriate verification mechanism:*

  ____ *Read back*

  ____ *Fax*

  ____ *E-mail*

- *Comments:*

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After verification, the completed information has been transferred to the operating room schedule.

Information taken by scheduling staff:

Name *(please print)*: ____________________

Signature: ____________________

Date: ____________________ Time: __________

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For more information, visit

http://www.patientsafetyauthority.org

This form is provided as a sample only and is not meant to be used as is.