OR Scheduling Form

Write legibly and do not use abbreviations

Today's Date:_____

Patient First Name: _____ Last Name:_____

Identifier 1: _____ Identifier 2: _____

Surgeon Name: _____ Date of Surgery: _____

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

_____

_____

_____

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:

_____

_____

_____

_____

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

Information taken by scheduling staff:	Name *(please print)*: _____ Signature: _____ Date: _____ Time: _____

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