SPS

TWIN COUNTY
Regional Healthcare
Where People Care

Patient Label

Surgical Services Posting & Order Sheet

Physician Name: _____
Procedure Date: _____

Patient Name:_____Age:_____DOB:____/____/_____Sex:_____

Parent(s) Name if Minor/ or Legal Guardian:_____

Home Phone:_____ Cell Phone:_____

Allergies:_____

Procedure:_____

CPT Code:_____/_____/_____ SSN:_____-_____-_____

Diagnosis:_____

Pathology or Frozen Sec. Y / N

Equipment or Rep:_____

Pre-Op Hosp. Date & Time_____ EST. Time of Procedure_____

Anesthesia Type:_____ Pediatrician:_____ Diabetic: Y / N

□ **Place in Outpatient** □ **Admit to Inpatient**
(Primary Care Physician) Family Doctor:_____ Other:_____

Tests to be completed:_____

Physician Signature:_____Date:_____Time:_____

Insurance Information:

Primary Ins:_____ Policy #:_____

Group#:_____Authorization #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Referral Required: Y / N On File: Y / N Second Opinion: Y /N Pre-Existing: Y / N

Worker's Comp:

Carrier Name:_____

Address::_____Phone #:_____

Claim #:_____ Employer Name:_____

Employer Address:_____ Phone #:_____