THOMAS HEALTH SURGERY SCHEDULING BOOKING SHEET

Facility: ☐ SFH-ENDO ☐ SFH-MAIN ☐ SFH-ODSC ☐ TMH-AMB ☐ TMH-ENDO ☐ TMH-MAIN

Patient Name: Last _____ First _____ Middle _____ Suffix _____

DOB: _____ / _____ / _____ Social Security Number: _____ - _____ - _____ Sex at Birth: ◯ M ◯ F ◯ U

Address: _____

Home Phone #: _____ - _____ - _____ Cell Phone #: _____ - _____ - _____

Admission Status after Surgery ◯ Inpatient ◯ Outpatient ◯ 23 Hour Observation

*Required Check Completed Against the Latest CMS Inpatient Only Procedures (IOP) List: ☐ YES By: _____

Type of Case: ◯ Elective ◯ Priority Elective (authorization is a priority)

Surgeon: _____ Assisting Surgeon: _____

Date of Surgery: _____ / _____ / _____ Time Surgery Requested: _____ PAT Preference Date: _____

Diagnosis: _____

Procedure(s) – include Site/Side: _____

CPT Codes(s) used to Obtain Authorization: _____

ICD-10 Code(s) used to Obtain Authorization: _____

Anesthesia Type Requested: ◯ GENERAL ◯ MAC ◯ LOCAL ◯ SPINAL ◯ CHOICE ◯ OTHER: _____

LATEX ALLERGY (needs to be 1st case of day): ◯ YES ◯ NO Other Allergies: _____

Imaging Needed During Case: ◯ YES ◯ NO Type: _____ Pathologist Needed During Case: ◯ YES ◯ NO

Visual Acuity/Function for Cataract Procedures: ◯ YES ◯ NO Special Tools/Equipment for Case: _____

Medicaid Sterilization Form: ◯ YES ◯ NO Required H&P Attached for Dental, Pediatric and Podiatry Cases: ◯ YES ◯ NA

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Physician Authorization: _____ or NPR _____ Valid Dates for Procedure: _____

Facility Authorization: _____ Valid Dates for Procedure: _____
(required if < 72 business hours before case)

Facility NPI: SFH - 1891732889 TMH - 1316925506

Fax to Appropriate Surgical Area:

TMH Ambulatory:	304-414-2720	TMH Endo/Minor:	304-414-2719	TMH Main OR:	304-766-4451
SFH ODSC:	304-347-6297	SFH Endo/Minor:	304-414-4941	SFH Main OR:	304-347-6894

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WVU Medicine
THOMAS HOSPITALS