THE HEART HOSPITAL Baylor Plano

Scheduling Request Form

Phone 469-814-3565 or 866-810-1168 Fax 214-818-6471 THHBPFXAS@baylorhealth.edu

DATE OF REQUEST: ____________________ REQUESTOR NAME: ______________________________

REQUESTOR PHONE: ______________________________ FAX: ______________________________

PHYSICIAN: ____________________ REQUESTED DATE: ______________ REQUESTED TIME: __________

ASSISTANT(S) OR PA FOR SURGERY OR PHYSICIAN BEING PROCTORED: ______________________________

ANESTHESIA GROUP OR INDIVIDUAL*: ____________________ ANESTHESIA TYPE: ______________

***THE PHYSICIAN'S OFFICE MUST ARRANGE FOR ANESTHESIA**

ADMIT TYPE (check one): ☐ Inpatient ☐ Day Surgery

PATIENT LAST NAME: ______________________ FIRST: ______________________ MI: ______

ADDRESS: ______________________ CITY: ____________ STATE: ______ ZIP CODE: ________

PRIMARY PHONE #: ______________ DOB: ____________ SSN: ____________ GENDER: ______

EMPLOYER: ______________________________ WORK PHONE #: ______________________

IF PATIENT IS A MINOR, GIVE THE MOTHER, FATHER, OR GUARDIAN'S NAME: ______________________

(If patient is a minor give mother, father, or guardian's work phone #): ______________________

PRIMARY INSURANCE CO. **(HMO, PPO, ETC.)** OR WORKMANS' COMP INFO: ______________________

PRIMARY POLICY HOLDERS NAME ______________________________ SS# ______________________

ADDRESS (if different than patient) ______________________________

CITY: ______________________ STATE: ______________ ZIP: ______________

RELATION TO PATIENT ______________________ PHONE IF DIFFERENT ______________________

GROUP NAME ______________________________ PRE-CERT #: ______________________

POLICY # ______________________________ GROUP # ______________________

INSURANCE PHONE # ______________________

SECONDARY INSURANCE CO (HMO, PPO, ETC.) ______________________________

GROUP NAME ______________________________

POLICY # ______________________________ GROUP # ______________________

INSURANCE PHONE # ______________________

CHIEF COMPLAINT: ______________________________

DIAGNOSIS *(include ICD-9 Code):* ______________________________

PROCEDURE(S): ______________________________

CPT/ICD9 CODE(S):

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EQUIPMENT NEEDED (please check): ☐ C-ARM ☐ X-RAY ☐ ICU BED ☐ OTHER ______________

IF OUTSIDE VENDOR NEEDED, PLEASE LIST EQUIPMENT, COMPANY, VENDOR REP. AND PHONE # HERE:

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PRE-ADMIT TESTING: Date: ______________ Time: ______________ Comments: ______________

TEST(S) REQUESTED: ☐ EKG ☐ LAB ☐ CXR ☐ OTHER (PLEASE LIST): ______________________

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