MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

SCHEDULING REQUISITION

SCHEDULING DESK
932-3271 OR 932-3275

FAX completed forms to:
974-7060

PATIENT INFORMATION

LAST NAME:	**FIRST NAME:**	**MI.**
MAIDEN /OTHER SURNAME:		
DOB: / /	**PHONE#: - -**	**☐FEMALE ☐MALE**

INSURANCE INFORMATION

POLICY NUMBER:					
☐QUEST INTREGRATION PLAN	**☐ALOHACARE**	**☐HMSA**	**☐KAISER**	**☐OHANA**	**☐UHC**
☐MEDICARE	**☐ADVANTAGE PLAN**				
☐HMSA	**☐PPO**	**☐HPH**	**☐AKAMAI**		
☐OHANA	**☐ADVANTAGE PLAN**				
☐KAISER	**☐ADDED CHOICE**		**☐SENIOR ADVANTAGE PLAN**		
☐UHC	**☐ADVANTAGE PLAN**				
☐VETERAN'S ADMIN	**☐WORKMAN'S COMP**		**☐OTHER:**		
COULD ANY PORTION OF THIS PROCEDURE BE CONSIDERED TO BE EITHER PROPHYLACTIC **(P)** OR COSMETIC **(C)**? ☐YES ☐NO					

AUTHORIZATION #	**EFFECTIVE DATES: / /**	**☐PRE-AUTHORIZATION NOT REQUIRED**
Status of Authorization confirmed by: Insurance Representative Name:		**Date: / /**

DIAGNOSIS	**ICD CODES**	
DIAGNOSIS:	**ICD 9 CODE:**	**ICD 10 CODE:**
SEC. DIAGNOSIS:	**ICD 9 CODE:**	**ICD 10 CODE:**

PROCEDURE		**TIME REQUIRED**	**CPT-4 CODE:**
	☐COSMETIC ☐PROPHYLACTIC		
	☐COSMETIC ☐PROPHYLACTIC		
	☐COSMETIC ☐PROPHYLACTIC		

ALL PATIENT INFORMATION ABOVE THIS LINE IS REQUIRED IN ORDER TO SCHEDULE A PROCEDURE

ANESTHESIA

☐GENERAL	**☐MAC**	**☐LOCAL**	**☐SPINAL**	**☐EPIDURAL**	**☐OTHER:**
BOOKING INFORMATION			**☐ELECTIVE**	**☐URGENT**	**☐EMERGENT**

DATE: / /	**TIME:**	**TYPE OF ADMISSION:**	**☐AM ADMIT**	**☐SDC**	**☐IN**	**☐SNF**	
SURGEON:							
ASSISTANT:							
PEDIATRICIAN:							

POSITIONING

☐SUPINE	**☐PRONE**	**☐LATERAL**	**☐↓RT**	**☐↓LT**	**☐LITHOTOMY**	**☐OTHER:**

SPECIAL REQUESTS/COMMENTS

PREOP TESTS:	**☐PT/PPT**	**☐CBC**	**☐CHEM 7**	**☐UA**	**☐EKG**	**☐CXR**	**☐T/S**	**☐UHCG PREG)**	**☐PATHOLOGY**