Office Information	
Today's Date:	
Attending Physician:	
First Assist:	
Office Number:	

Patient Information		
Name:		
Date of Birth:	Gender: ⌖ Male ⌖ Female	
Address:		
City:	State:	Zip Code:
SSN:		Language:
Primary Phone Number:		Primary Contact:
Primary Care Provider:		

*Copy of ID and insurance card to be attached when submitting this booking sheet

Patient Booking Information		
Height:		Weight:
Medical Devices:	⌖ Pain Pump ⌖ Neurostimulator ⌖ Cardiac Device ⌖ Shunt ⌖ Stent	
Dialysis	⌖ Yes ⌖ No	If yes, last or next scheduled appointment:
Diabetes:	⌖ Yes ⌖ No	If yes, Insulin Pump: ⌖ Yes ⌖ No
Hx of Stroke	⌖ Yes ⌖ No	
Latex Allergy:	⌖ Yes ⌖ No	
Medication Allergy:	⌖ Yes ⌖ No	If yes, which medications:
Food Allergy:	⌖ Yes ⌖ No	If yes, which foods:
Adhesive Allergy	⌖ Yes ⌖ No	If yes, which adhesive:
Patient on blood thinner:	⌖ Yes ⌖ No	If yes, which one:
Isolation:	⌖ Yes ⌖ No	If yes, which precautions: ⌖ Contact ⌖ Droplet ⌖ Airborne
Rehab Order:	⌖ Pre-operative ⌖ Post-operative ⌖ N/A	

Case Information	
Date of Surgery:	Start Time:
Diagnosis:	
OR Location: ⌖ USPI ⌖ GSMC	
Admit Status: ⌖ AMB / Outpatient ⌖ Admit / Inpatient ⌖ Inhouse / Inpatient	
PAT Date: ⌖ N/A	Time:
Authorization #:	
Procedure(s):	
Estimated Length of Procedure:	
CPT Codes:	
Implant(s):	
Tissue or graft type needed: ⌖ Patient's Own ⌖ Cadaveric ⌖ N/A	Type:

Laterality

⌖ Left	⌖ Right	⌖ Posterior	⌖ Anterior	⌖ Lateral	⌖ Medial
⌖ Left Lateral	⌖ Right Lateral	⌖ Left Medial	⌖ Right Medial	⌖ Bilateral	⌖ Bilateral Lateral

Case Classification

⌖ Elective ⌖ Emergent ⌖ Partially Cosmetic ⌖ Return to OR ⌖ Urgent

Special Needs

⌖ Hana Table	⌖ Jackson Table	⌖ Beach Chair	⌖ Navigation	⌖ Conformis
⌖ Lateral Position	⌖ Supine Position	⌖ Prone Position	⌖ Microscope	⌖ Spider
⌖ Mini C-Arm	⌖ Large C-Arm/Image Intensifier		⌖ Mako	⌖ X-Ray (Flat Plate)

Anesthesia Technique and Post Op Pain Management

⌖ As per anesthesia	⌖ General	⌖ Neuraxial block	⌖ Peripheral nerve block
⌖ No Pre-op Block	⌖ Post-op Block PRN	⌖ MAC	⌖ Peripheral nerve catheter

Additional Orders