Please fax the completed form
to 909-568-2191

CASA COLINA
Hospital and Centers for Healthcare

255 E. Bonita Avenue
Pomona, CA 91767
Surgery Scheduling 909-568-2180
or 909-596-7733 x 2591

SURGICAL SCHEDULING FORM

Patient Information

Date _____

Patient Name _____ Gender ❑ Male ❑ Female

DOB _____ SSN _____

Address _____ City _____ Zip _____

Home Phone _____ Alternate/Cell Phone _____

Primary Care Physician _____

Surgeon Name _____ Assisting Surgeon _____

Surgeon Office Contact _____ Phone _____

Procedure Information

Procedure _____

Procedure description _____

Length of Procedure _____ Requested date _____ Requested time _____

Procedure Details

Diagnosis		
CPT Code(s)		
ICD-10 Code(s)		
Anesthesia	❑ General ❑ Regional ❑ MAC ❑ Moderate Sedation ❑ Local	
Anticipated Post-op Level of care	❑ Outpatient ❑ AM Admission (Med/Surg - ICU) ❑ Observation (23 hour hold)	
Special Equipment/Implants	Vendor:	Rep Name:
	Rep Phone Number:	Date Contacted:
DME required after surgery	❑ Yes ❑ No	What is required ? ❑ Office to arrange & patient will bring
Comments/Special Patient needs		

Insurance Information

Please attach copy of insurance card.

Insurance name _____ Subscriber _____

Insurance ID Number _____ ❑ PPO ❑ HMO

Secondary Insurance (if applicable)

Insurance name _____ Subscriber _____

Insurance ID Number _____ ❑ PPO ❑ HMO

(Casa Colina use only)

Confirmation

Account Number _____

Case Confirmation Number _____ Scheduler's name _____