

**PHYSICIAN BOOKING SHEET FOR SCHEDULING SURGERY
AT HCA FLORIDA JFK HOSPITAL**

Date booked: _____ Time: _____ Length of Procedure: _____

Patient Name: _____ Sex (M/F) _____ Phone #: _____

Cell #: _____ Email: _____

D.O.B.: ____/____/____ SS# (last 4 digits): _____ Authorization #: _____

Insurance: _____ Insurance Plan Description: _____

Procedure/Surgery: _____

Policy Number: _____

Procedure/Surgery with laterality if applicable: _____

Diagnosis & Code: _____

Medical Clearance at JFK with ARNP

Special Needs/Facility Equipment/First assist: _____

Company/Equipment: _____

Date of Surgery: ____/____/____ Type of Anesthesia: _____

Time of Surgery: _____ Procedure/CPT Code(s): _____

_____ Admit to In-patient _____

_____ Admit to Outpatient _____

Surgeon's Name: _____ Surgeon's Fax: _____

Ordering Surgeon's Signature & NPI #: _____

Scheduler's Email: _____

Cases Scheduled by PHONE:

Call:

Cases Scheduled by FAX - (Complete this Form):

Fax:

ALL Pre-Operative Orders, including pertinent documents:

Fax:

Please ensure form is completely and fully filled out, otherwise we will not be able to schedule surgery and we will have to call you to complete.

Not Part of the Legal Health Record