

THE NEW YORK EYE AND EAR INFIRMARY



BLOCK TIME
 NON-BLOCK TIME
 (866) 333-0191
 ALREADY BOOKED ~~AA~~
 REVISED ON: _____

PROCEDURE (S)		CPT Code(s)
1 SURGEON: _____		_____
ASST. SURGEON: _____		_____
2 SURGEON: _____		_____
ASST. SURGEON: _____		_____
SURGICAL COORDINATOR 1: _____		PHONE _____
Date of Surgery _____	Req. Time _____	AM <input type="checkbox"/> PM <input type="checkbox"/> Duration Time _____ Stay _____ day(s)
Date: _____		
Patient Last Name _____ (M <input type="checkbox"/> F <input 2"="" type="checkbox/>)</td> <td>Unit # _____</td> </tr> <tr> <td colspan="/> Patient First Name _____ Marital Status (M <input type="checkbox"/> S <input 2"="" type="checkbox/>)</td> <td>DOB _____ Age: _____</td> </tr> <tr> <td colspan="/> TEL: Residence _____ Work _____		Ext: _____ Other _____
Street Address _____ APT# _____		SS# _____
City _____ State _____ Zip _____		
Parent/Guardian _____		DOB _____
Emergency Contact/Spouse _____		Tel _____
ADMISSION SOURCE: AMB Inpatient Pvt. Clinic		
Admission Date _____ Service: Eye <input type="checkbox"/> Ent <input type="checkbox"/> Oral <input type="checkbox"/> Plastic Pain Management		
Anesthesia (check one): General <input type="checkbox"/> Mac/Topical <input type="checkbox"/> Local <input type="checkbox"/> Mac <input type="checkbox"/> Topical <input type="checkbox"/>		
Requested by: _____ AA Patient known to NYEE Yes <input type="checkbox"/> No <input type="checkbox"/>		
Pre-Admission Testing at Hospital Yes <input type="checkbox"/> No <input type="checkbox"/> Date of PAT _____ Time of PAT _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		
DIAGNOSIS(ES) _____		ICD-9 _____
FOR PRECERT _____		ICD-9 _____
_____		ICD-9 _____
_____		ICD-9 _____
Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/>		
Allergies _____		
Special Equipment/Instructions _____		<input type="checkbox"/> Latex Sensitive
For Plastic Cases only: P.A. Yes <input type="checkbox"/> No <input type="checkbox"/> Frozen Section Required: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Comments: _____		
Multifocal Ocular Lenses: Order Quantity <input type="checkbox"/> Crystal Lens <input type="checkbox"/> Crystal w/HD <input type="checkbox"/> Restor Lens <input type="checkbox"/> Rezoom Lens <input type="checkbox"/> Toric Lens <input type="checkbox"/> Tecnis Lens		
Cochlear Implant Type: AB90KH <input type="checkbox"/> AB90KJ1 <input type="checkbox"/> CCNUC24 <input type="checkbox"/> CCNUCADV <input type="checkbox"/> CCNUCDBL <input type="checkbox"/> CCNUCREE <input type="checkbox"/> MECOMPRESS <input type="checkbox"/> MEDSPLIT MESTANDARD <input type="checkbox"/>		
SPECIAL NEEDS: Is From a Nursing Home <input type="checkbox"/> With Dementia <input type="checkbox"/> Stretcher Bound (Cannot Ambulate) <input type="checkbox"/> Needs a Wheelchair <input type="checkbox"/> Behavioral Problem Companion <input type="checkbox"/>		
Types of Needs Blind Monocular <input type="checkbox"/> Hearing Impaired Uses Sign Language <input type="checkbox"/> Needs a Seeing Eye Dog <input type="checkbox"/> Language Barrier Parent to Stay in Room <input type="checkbox"/>		
Oxygen Dependent <input type="checkbox"/> Ventilator Dependent <input type="checkbox"/> Has Tracheostomy <input type="checkbox"/> With Colonostomy <input type="checkbox"/> Latex Allergy Dialysis <input type="checkbox"/> Defibrillator <input type="checkbox"/>		
PLEASE NOTE: ALL CASES STARTING BEFORE 9:00 A.M. MUST HAVE THE PRE-TESTING RESULTS AND THE PRE-ADMISSION FORMS 72 HOURS IN ADVANCE. ALSO, ALL INSURANCE INFORMATION MUST BE COMPLETE WITH AUTHORIZATION NUMBERS ATTACHED.		
H&P to be provided by: _____		Office Phone Number _____
Insurance Information Physician Accepts Insurance Yes <input type="checkbox"/> No <input type="checkbox"/>		If "No" check one: Out of Network <input type="checkbox"/> Self- Pay None <input type="checkbox"/>
Primary Insurer _____		Secondary Insurer _____
Policy Holders Name _____		Policy Holder's Name _____
Relation to Patient _____		Relation to Patient _____
Policy # _____ Group _____		Policy # _____ Group _____
Ins. Tel # _____ Effec Date _____		Ins. Tel # _____ Effect Date _____
If HMO, who is PCP _____		If HMO, who is PCP _____
PCP Tel # _____		PCP Tel # _____
Employer _____		Employer _____
Employer Tel# _____		Employer Tel# _____
PRECERT# _____ Date _____		PRECERT# _____ Date _____
Comments, No-Fault/Workers Comp. Information _____		