CSH Pre-Admission Orders /Admission Schedule

***Please provide as much information as possible*Fax this schedule & a copy of the patient's insurance card (front & back)**

***FAX all information to: (304) 353-0329**

Physician:	Time of Arrival:
Date of Surgery:	Type of service:
Referring Physician (Full Name):	Ref Physician Phone: Fax:
Last Name: Maiden Name:	Patient's **Social Security** #:
First Name: MI:	DOB:
Mailing Address:	Age:
City: State: Zip Code:	Gender: Male Female
Home Phone:	
Work Phone: Cell Phone:	**E-Mail Address**:
Latex allergy?	Anesthesia Type:
History of MRSA? Yes No	
Surgical Procedure Description:	
Please indicate:	
Surgical Procedure **Code: (CPT-4)**	
Admitting Diagnosis (no abbreviations please):	
Admitting Diagnosis **ICD-9/ICD-10 Code**:	
Is there any Testing or Antibiotics Needed on Admission: (If Yes please list here):	
Pre-Admitting Testing Orders: (check all needed) CBC PTT PT BMP CMP H&H EKG	
PAT (scheduled) Date: Time:	
Imaging Type: X-Ray MRI Ultrasound Other	Body Part Being Imaged:
Type of Insurance	**Insurance ID#**
Secondary Type of Insurance	Secondary Insurance ID#
Authorization Number	Insurance Rep Name
Reference Number	

Physician Signature Date

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