

CSH Pre-Admission Orders /Admission Schedule



1306 Kanawha Blvd. East Charleston WV, 25301

304-343-4371

**Instructions: Please provide as much information as possible.
Fax this document and a copy of the patient's insurance card (front & back) to 304-353-0329.**

Physician:		Time of Arrival:	
Date of Surgery:		Type of service:	
Referring Physician (Full Name):		Ref Physician Phone:	Fax:
Physician's Office Notification Email:			
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			
Additional Orders:			
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			
PACKET CHECKLIST:		H&P	Insurance Card Drivers License
CSH INTERNAL USE ONLY: Patient Account #:			

Physician Signature: _____

Date: _____