



1SPS

Surgical Services Posting & Order Sheet
Twin County Regional Hospital

Physician Name: _____

Procedure Date: _____

Patient Name: _____ Age: _____ DOB: ____/____/____ Sex: _____

Parent(s) Name if Minor/ or Legal Guardian: _____

Home Phone: _____ Cell Phone: _____

Allergies: _____

Procedure: _____

CPT Code: ____/____/____ SSN: ____-____-____

Diagnosis: _____

Pathology or Frozen Sec. Y / N

Equipment or Rep: _____

Pre-Op Hosp. Date & Time _____ Procedure Duration _____

Anesthesia Type: _____ Pediatrician: _____ Diabetic: Y / N

☐ **Place in Outpatient** ☐ **Admit to Inpatient**

(Primary Care Physician) Family Doctor: _____ Other: _____

Tests to be completed: _____

Physician Signature: _____ Date: _____ Time: _____

Insurance Information:

Primary Ins: _____ Policy #: _____

Group#: _____ Authorization #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Referral Required: Y / N On File: Y / N Second Opinion: Y / N Pre-Existing: Y / N

Workman's Comp:

Carrier Name: _____

Address: _____ Phone #: _____

Claim #: _____ Employer Name: _____

Employer Address: _____ Phone #: _____