

**Green Valley Parkway Location**

100 N. Green Valley Pkwy., #125  
Henderson, NV 89074  
702.616.4944

Please fax to Mary:  
Fax: 702.616.4962 Efax: 702.974.1106



*A Joint Venture with St. Rose Dominican and United Surgical Partners*

**Scheduling Form**

**Horizon Ridge Location**

10561 Jeffreys St., #130  
Henderson, NV 89052  
702.724.8900

Please fax to Mary:  
Fax: 702.616.4962 Efax: 702.974.1106

PHYSICIAN \_\_\_\_\_ Patient Acct # \_\_\_\_\_

CPT \_\_\_\_\_

\_\_\_\_\_ DOS \_\_\_\_\_

\_\_\_\_\_ TIME \_\_\_\_\_

PT. NAME (LAST/FIRST) \_\_\_\_\_ SEX: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME PH#: \_\_\_\_\_ INSURANCE \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ DOI: \_\_\_\_\_

SELECT ONE: HMO POS PPO EPO

PATIENT SS# \_\_\_\_\_ INSURANCE ID# \_\_\_\_\_

(incl. prefix/suffix)

INSURANCE PHONE # \_\_\_\_\_ INSURED'S NAME \_\_\_\_\_

SS# OF INSURED (if other than patient): \_\_\_\_\_ AUTH # \_\_\_\_\_

2ND INSURANCE: (if applicable) \_\_\_\_\_

INSURED: \_\_\_\_\_ INSURANCE ID# \_\_\_\_\_

(incl. prefix/suffix)

INSURANCE PHONE # \_\_\_\_\_ AUTH # \_\_\_\_\_

PROCEDURE \_\_\_\_\_

IMPLANTS \_\_\_\_\_

ICD-10 / DIAGNOSIS: \_\_\_\_\_

Special Request: \_\_\_\_\_

**(PLEASE SELECT REQUESTS BELOW)**

XRAY Yes | No

PREFERENCE: Mini C-Arm Large C-Arm

XRAY TECH NEEDED? Yes | No

Anesthesia Group/Type: \_\_\_\_\_ Length of Time: \_\_\_\_\_

PSC Rep \_\_\_\_\_ SCHEDULER'S NAME \_\_\_\_\_

Date: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*Items in Bold Print are required information!!  
We must also have a copy of each valid insurance card faxed to us.**

## PRE-ADMISSION TESTING

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Diagnosis/ICD10 Code: \_\_\_\_\_  
 Surgical Procedure/Consent: \_\_\_\_\_

Date of Procedure: \_\_\_\_\_ Surgeon's Name: \_\_\_\_\_

**ORDERS:**

1. Admit to Parkway Surgery Center
2. Start I.V. with  1000cc Ringers Lactate  500cc Ringer's Lactate
3. Other orders: \_\_\_\_\_

Physician Requested LAB TESTS:  Check or Circle test to be ordered

<p><input checked="" type="checkbox"/> <u>Female Patient's</u></p> <p><input type="checkbox"/> CBC</p> <p><input type="checkbox"/> Urine Pregnancy (Menstruating Females)</p> <p><input checked="" type="checkbox"/> <u>Female Patient's (Age &gt; 50)</u></p> <p><input type="checkbox"/> EKG</p> <p><input type="checkbox"/> CBC</p> <p><input type="checkbox"/> Chem Panel</p>	<p><input checked="" type="checkbox"/> <u>Male Patients's Age &gt;40</u></p> <p><input type="checkbox"/> EKG</p> <p><input checked="" type="checkbox"/> <u>All Patients Age &gt; 60</u></p> <p><input type="checkbox"/> CBC</p> <p><input type="checkbox"/> Chem Panel</p> <p><input type="checkbox"/> EKG</p> <p><input type="checkbox"/> CXR (PA/Lateral) as indicated by history</p>
<p><input checked="" type="checkbox"/> <u>Diabetics: Patient's taking Diuretics or Cardioactive Drugs</u></p> <p><input type="checkbox"/> Chem Panel</p> <p><input type="checkbox"/> Accucheck (for all Diabetic Patients on Admission)</p> <p><input checked="" type="checkbox"/> <u>No Test's Required</u></p>	<p><input checked="" type="checkbox"/> <u>Other</u></p> <p><input type="checkbox"/> PT</p> <p><input type="checkbox"/> PTT</p> <p><input type="checkbox"/> Crutch Training</p> <p><input type="checkbox"/> _____</p>

Labs for patients on K+ depleting drugs should be < 2 weeks old.

If Patient had an EKG within the last 6 months - Please fax results to Parkway Surgery Center.

**FAX ALL RESULTS TO PARKWAY SURGERY CENTER 702.269.0428**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



**Green Valley Location**  
 100 N. Green Valley Parkway, Suite 125  
 Henderson, Nevada 89074  
 Phone (702) 616-4954  
 Fax (702) 269-0436

**Horizon Ridge Location**  
 10561 Jeffreys Street, Suite 130  
 Henderson, Nevada 89052  
 Phone (702) 724-8900  
 Fax (702) 982-8854

**PATIENT SHOULD BRING COPY ON DAY OF REGISTRATION**