UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Central Posting Office: 443-843-6540
Central Posting Fax: 443-843-6043
FAX PST: HMH (443)843-7953/UCMC 643-3663

Surgical Posting Request Form

Today's Date:____/_____/_______ **Date of Surgery:**_____/_____/_______ **Start Time:**_____

Facility: □ HMH □ UCMC □ UCMC-ASR (by BLOCK only) **Surgeon**: _____

PATIENT INFORMATION * (Mandatory field)

* Name: _____ * Social Security Number: _____-_____-_____

Address: _____

* Contact #: (_____) _____-_____ * DOB: _____/_____/_____ Gender: □ Male □ Female

INSURANCE INFORMATION

Primary Insurance: _____ Guarantor: _____

Policy #: _____ Authorization: _____

Secondary Insurance: _____ Guarantor: _____

Policy #: _____ Authorization: _____

SCHEDULED PROCEDURE INFORMATION	Laterality	CPT Code	ICD-10
Preop Diagnosis	□ **Right** □ **Left** □ **Bilateral**		
Procedure	□ **Right** □ **Left** □ **Bilateral**		
Preop Diagnosis	□ **Right** □ **Left** □ **Bilateral**		
Procedure	□ **Right** □ **Left** □ **Bilateral**		

ANESTHESIA PROVIDER REQUIRED: □ Yes □ No □ LOCAL anesthesia only

Patient admission plan: □ To Be Admitted □ Discharge DOS □ **Outpatient Extended Recovery** **Procedure duration:** _____

First Assistant requested: □ Yes □ No Name FA: _____

Second Assistant requested: □ Yes □ No Name SA: _____

Studies completed related to this procedure: □ CT Scan □ MRI □ XR □ US □ other: _____

Location where completed: _____

***Other procedures required DOS:** □ Mammography □ Xray □ CT Scan □ MRI □ Asterand Protocol □ **(Account number ALERT)**

Surgical equipment required: □ C-Arm □ O-Arm □ Neuromonitoring □ Stealth □ Cell saver □ Microscope □OTHER:_____

Equipment:_____

_____

_____

Vendor notified by office: □ YES □ NO Vendor name and contact #: _____

LABORATORY/Blood Bank Notifications: Frozen Section anticipated: □ YES □ NO

Blood Bank: # of units: ____ □ Autologous □ Directed donor □ Allogenic

Tissue products/allograft: TYPE: _____ Quality: _____ Size: _____

Product Description:_____

PRESURGICAL TESTING INFORMATION Site:□ HMH □UCMC

Does patient: Weigh > 300 pounds? □YES □ NO Actual weight: _____

Have implanted cardiac device: □ Yes Type/vendor info: _____

ALL INFORMATION MUST BE RECEIVED IN PST 24 HOURS PRIOR TO DATE OF SURGERY