HVAS Hudson Valley Ambulatory Surgery, LLC
Same Day Surgery Experts
75 Crystal Run Road, Building B, Suite 225, Middletown, NY 10941 T: (845) 692-9900 F: (845) 692-0800

Surgical Orders/Consent Scheduling Form

PATIENT NAME _____
Last First MI

ADDRESS _____

DOB Age SS number ☐ **MALE** ☐ **FEMALE**

TELEPHONE NUMBER:
Home: _____ Cell: _____ Work: _____

Insurance Company (Primary) **ID Number** **Pre-Certification #**

Insurance Company (Secondary) **ID Number** **Pre-Certification #**

Subscriber Name **Subscriber DOB** **Relationship to patient**

SURGERY DATE: _____ **MD Available Time:** _____

SURGEON: _____ **Assistant (if required):** _____

LATEX ALLERGY: ☐ Yes ☐ No (Please check one)

OTHER ALLERGIES: _____

DIAGNOSIS: _____

ESTIMATED LENGTH OF SURGERY: _____ **CPT CODE:** _____

CONSENT FOR SURGICAL PROCEDURE _____

INJURY: ☐ Yes ☐ No (Please check one)
Explain: _____

SPECIAL EQUIPMENT: _____

Check Pre-Procedure Studies: **Presurgical Package given:** ☐ Yes ☐ No (Please check one)
☐ Hgb/Hct ☐ CBC ☐ PT ☐ APTT ☐ BMP ☐ CMP ☐ Pregnancy (ages 12-55) ☐ Urinalysis
☐ Urine culture Other: _____

Pre-Op Antibiotics: _____
☐ IV Solutions _____ Other: _____
Other Special Instructions: _____
☐ Medical Consultation by Dr.: _____ Reason: _____
Physician Signature: _____ Printed Name: _____

OFFICE STAFF SIGNATURE: _____ Date: _____