Surgery Information

Please complete this form for all surgeries/procedures that are not performed in office.
Please do not schedule the surgery/procedure until you have received the processed referral back from AHN.

Patient Information	
Name:	**DOB:**

Surgery Information
Surgeon:
Assistant Surgeon:
Assistant Surgeon Phone (if different from surgeon):
Name of Facility/Surgery Center:
Out-Patient/Same day: ☐ **In-Patient:** ☐ **_ Days In-Patient: 23HR Obs.** ☐
Expected Date of Surgery:
Name of Surgery/Procedure:
CPT Code(s):
Preferred Anesthesia Group:
Expected Length of Surgery (minutes/hours):
Hardware/Implant Information: Please list the make/model, quantity and manufacturer for any implants/hardware that will be used during the course of the surgery/procedure.

Provider Office Information	
Office Contact Name:	**Phone:**
Today's Date:	

Please fax completed form to 775-284-1053