Surgery Information

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

Routine_____Urgent:_____STAT: _____

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):

<u>Hardware/Implant Information List:</u>

HIP REPLACEMENT*:_____Cemented_____No Cement
HIP REVISION*:_____Cemented_____No Cement
KNEE REPLACEMENT*:_____Total____Custom__ Uni_____Poly_____High Flex Cutting Blocks/Jigs All Metal
KNEE REVISION*:_____List Components and Vendor below
SHOULDER REPLACEMENT*:____Standard_____Reverse
SHOULDER REVISION*:_____*
SPINE FUSION*: Number of Levels _____
Bone & Biologics: Volume per Level (CC): _____
FRACTURES*: Location (body part)_____
Tissue/Grafts Manufacturer _____
HERNIA REPAIR:_____Mesh_____Size_____Manufacturer _____
GYN:_____Pelvic Floor Sling Manufacturer _____
OTHER: _____

***Vendor/Manufacturer** **(requested by physician):** _____

***Components/Hardware** **(requested by physician):** _____
_____
_____

access MEDICAL

Provider Office Information	
Office Contact Name:	**Today's Date:**
Originating Physician: _____ **Preferred form of communication:** **Phone:_____ Fax:_____ Email:_____**	

Please fax completed form to 775-284-1053