TULANE MEDICAL CENTER- PERIOPERATIVE SERVICES

OR CASE CLINICAL JUSTIFICATION FORM

DATE: __________________ **TIME SUBMITTED:** ___________________________

COMMUNICATED TO: ______________________________ Highlighted areas are mandatory fields

PROCEDURAL CLASSIFICATION: **A procedural class MUST BE documented.**

☐ **Class A Emergency:** -- life, limb, or organ threatening conditions requiring immediate intervention

☐ **Urgent Class B Priority: --** not life threatening but may lead tp severe complications if procedure is not performed within 8 hours of classification

☐ **Class C Add-on Priority: --** not life threatening but may lead to complications if procedure is not performed within 24 hours

☐ **Class D- Elective Same Day/Next Day add-on** (form to be utilized for next day add-on cases when scheduling office is closed)

Individual completing the form MUST notify the ON-Call Anesthesia Staff to initiate pre-op clearance.

SURGEON: ________________________________ **REQUESTED PROCEDURAL DATE:** ______________

SURGEON AVAILBILITY: _____________________ **TIME:** ______________

DIAGNOSIS: ____

PROCEDURE CPT CODE: ______________________ ______________________

(REQUIRED AS OF 12/2015- CASE WILL NOT BE CONSIDERED SCHEDULED WITHOUT CPT (except Class A emergent cases)

PROCEDURE: ____

LATERALITY: RIGHT LEFT BILATERAL N/A
(CIRCLE)

ESTIMATED PROCEDURAL LENGTH: ______ HOURS _____ MIN

FORM COMPLETED BY: _________________________ **CONTACT NUMBER:** ________________

SPECIAL PROCEDURE NEEDS: FLURO

VENDOR: ___________________________
CONTACTED: _____ yes ___ no

MICROSCOPE NEURO MONITORING

OTHER: ___________________________

SPECIAL PT POSITIONING: ___ Prone ___ Lateral ___ Jackson Table _________ Other

COMMENTS: ____

____

____
Surgeon Signature

PATIENT LABEL/ID

DOCUMENTATION MUST INCLUDE TWO ACCEPTABLE PATIENT IDENTIFIERS (Name, MR#, DOB)