



SURGERY RESERVATION

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PATIENT INFORMATION

PLEASE PATIENT'S LABEL HERE

PHONE: 504-897-8438 FAX: 504-897-7853

Booking Case # _____

Request Surgery Date: _____ Time/Length of Procedure: _____ hours

Request Pre-Op Appointment Date: _____ Time: _____

Please Call 504-897-7771 to Schedule a Pre-Op Appointment. If Not Requested Above

Patient Name: _____ DOB: _____

Patient SS#: _____ M/F: _____ M/F _____ MR#: _____ RM#: _____

Address: _____

Patient Phone #: (____) _____ Patient Ins.: _____

Office Staff Name: **Delecia Allen, RN** Office#: **504.988.5271** Fax#: **504-897-8769**

Surgeon Name: **Wayne Hellstrom, MD** Assistant Surgeon: _____

Procedure 1. **Inflatable penile prosthesis removal** CPT Code: **54406**

Procedure 2. _____ CPT Code: _____

Procedure 3. _____ CPT Code: _____

Procedure 4. _____ CPT Code: _____

Please check all items/Equipment needed for Procedure:

<input type="checkbox"/>	Stryker Video	<input type="checkbox"/>	Robotic # Arms
<input type="checkbox"/>	Stryker Ortho	<input type="checkbox"/>	Docking Side: (<input type="checkbox"/> Supine <input type="checkbox"/> Prone)
<input type="checkbox"/>	Gold Laser	<input type="checkbox"/>	Lithotomy
<input type="checkbox"/>	CO2 Laser	<input type="checkbox"/>	Jack Knife
<input type="checkbox"/>	Holmium Laser (<input type="checkbox"/> Inhouse <input type="checkbox"/> Vendor)	<input checked="" type="checkbox"/>	Anesthesia:
<input type="checkbox"/>	Biomet	<input checked="" type="checkbox"/>	General
<input type="checkbox"/>	Depuy	<input type="checkbox"/>	Mac
<input type="checkbox"/>	Synthes	<input type="checkbox"/>	Spinal
<input type="checkbox"/>	Fusion Navigation (<input type="checkbox"/> Scan at Touro <input type="checkbox"/> Scan on disc)	<input type="checkbox"/>	Epidural
<input type="checkbox"/>	Neuromonitoring	<input type="checkbox"/>	Local
<input type="checkbox"/>	Neoprobe (<input type="checkbox"/> Inhouse <input type="checkbox"/> Vendor)	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Medtronic Robtic SI	<input type="checkbox"/>	
<input type="checkbox"/>	Robotic XI	<input type="checkbox"/>	

Admit Type: ___ Inpatient Outpatient/23hr. Stay ___ AM Admit

Patient Diagnosis and ICD-10 Code: **Erectile dysfunction, N52.9**

Instruments/Implants: _____

Please contact OR Material Coordinator for any special requests @ 897-7020

Printed Name of Hospital Representative: Wayne Hellstrom, MD Delecia Allen, RN		Office #: 504.988.5271	Fax #: 504-897-8769
Hospital Representative's Signature: X		Date MM/DD/YY / /	Time 00:00 AM/PM :

