Touro
LCMC Health

SURGERY RESERVATION

PATIENT INFORMATION

PLACE 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 revision CPT Code: 54410

Procedure 2._____ CPT Code:_____

Procedure 3._____ CPT Code:_____

Procedure 4._____ CPT Code:_____

Please check all items/Equipment needed for Procedure:

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

Admit Type: ___Inpatient X 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:	Office #:	Fax #:
Wayne Hellstrom, MD Delecia Allen, RN	504.988.5271	504-897-8769

Hospital Representative's Signature:	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	: