



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#: _____ Fax#: **504-897-8769**

504.988.5271

Surgeon Name: **Lawrence Jenkins, MD** Assistant Surgeon: _____

Procedure 1. **Malleable penile prosthesis placement** CPT Code: **54400**

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

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: Lawrence Jenkins, 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 :

