HSHS St. John's Hospital

PAIN CLINIC SCHEDULING/ PHYSICIAN ORDER

Main
217–757–6060 phone

fax all preadmission information
to 217–757–6018

Tracking # _____ Issued by _____

Procedure date:_____/____/_____

Surgeon:_____

Times:_____

Procedure(s)/consent for:_____

Side needed: _____ YES _____ NO

(First) (MI) (Last) Female

Patient name:_____ Male

DOB:_____/_____/_____ Social Security #_____–_____–_____ Email:_____

Home address:_____

Phone #:_____

Insurance Carrier:_____ Precert #_____

Pre–Op Diagnosis ICD10_____

Check all the apply

- ❑ Latex Allergy
- ❑ MRO
- ❑ VRE
- ❑ Contrast Allergy

PRE–OP TESTING

- ❑ EKG
- ❑ Chest X–ray
- ❑ CBC w/diff
- ❑ BMP
- ❑ CMP
- ❑ MG
- ❑ PT/INR
- ❑ PTT
- ❑ U/A
- ❑ Urine C&S
- ❑ UHCG

PLEASE FAX ALL PRE ADM. ORDERS, H&P, CONSENTS AND TESTING RESULTS WITH THIS FORM TO 217–757–6018

Physician Signatuure:_____ Date:_____ Time:_____