Children's Mercy KANSAS CITY

Surgery Scheduling

Phone: (816) 234-3873
Fax completed Surgery Scheduling form to: (816) 302-9639

Date _____

PATIENT INFORMATION

First Name:_____ Last Name:_____

DOB:____/___/_____ Gender: _____ CMKC Medical Record Number:_____

PARENT/GUARDIAN INFORMATION

First Name:_____ Last Name:_____ Relationship: ❍ Parent ❍ Guardian

Preferred Phone: _____ Alternate Phone:_____

Preferred Language:_____

Primary Address:_____

City:_____ State:_____ Zip:_____

SURGERY INFORMATION

Date of Procedure:____/___/_____ Surgeon Name:_____ ❍ Adele Hall Campus ❍ Hospital Kansas

ADMISSION STATUS:

Inpatient:_____ AmAdmit:_____ SDS:_____

Extended Stay (less than 6 hrs):_____ Extended Stay Overnight (23 hrs):_____

Diagnosis:_____

Procedure:_____

_____ Procedure Length:_____

Special Equipment:_____

_____

Medical History: *(Diabetes, latex precaution or allergy; cardiac; seizures; anesthesia complication in family; other medical or surgical history, allergy)*

_____

_____

H&P: Completed:_____ To be completed by:_____ Date:_____

Preop Testing: Y/N Done:____/___/____ To be done:____/_____/_____

Consent to be obtained from:

Birth or Adoptive Parent:_____ Legal Guardian:_____

Patient over 18 or Emancipated:____ Child in custody of DFS or other agency:_____

Name of Case Worker:_____

Phone Number of Case Worker:_____

H&Ps and signed Consent Forms should be faxed to the appropriate Surgery Clearinghouse location below:

Children's Mercy Adele Hall Campus: (816) 302-9928 **Children's Mercy Hospital Kansas: (913) 264-9983**

Form completed by: _____ Phone: _____