Citrus Valley Health Partners
L&D Surgery Scheduling Form

Campus: ☐ **FPH** (Fax: 626-857-3109)
☐ **QVH** (Fax: 626-814-2581)

Procedure Information

Procedure Date (mm/dd/yy): ________ **Start Time (hh:mm):** ________ ☐ AM ☐ PM **Est. Length:** ______ min

Surgeon: ____________________ **Assistant:** ____________________

Procedure : ☐ Primary Cesarean Section **Reason:** ____________________
☐ Repeat Cesarean Section
☐ Other (e.g. tubal ligation) ____________________

EDC (due date): ________ ☐ Twins ☐ Surrogacy ☐ Adoption

High Risk (Please explain): ____________________

CPT Codes: ____________________

Diagnosis (*No Abbreviations Please*):

ICD-10 Codes: ____________________

Anesthesia Type (*Please Choose One*): ☐ General ☐ MAC ☐ Epidural ☐ Spinal

Special Considerations: *Latex Allergy:* ☐ Y ☐ N *Sleep Apnea:* ☐ Y ☐ N ☐ Unknown

Special Considerations (e.g. Transfusion-free & isolation):

Patient Information

Last Name: ____________________ **First Name:** ____________________

Gender: ☐ Male ☐ Female **Date of Birth:** ________ **Social Security Number:** ________

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other: ____________________

Primary Phone Number: ________ **Secondary Phone Number:** ________

Street: ____________________ **City:** ________ **State:** ______ **Zip:** ______

Primary Care Physician's Name: ____________________ **Phone:** ________

Insurance & Admission Information

Insurance: ____________________ **Policy Number:** ________

Insurance ID: ________ **Authorization Number:** ________

Admit Type: ☐ AM Admit ☐ Inpatient - Room: ________

Supply and Equipment Information

Special Equipment/ Requests:

Completion Information

Person Completing Form: ____________________ **Date:** ________

Phone: ________ **Ext.:** ________ **Fax:** ________

Please fax the form above to the approrpiate scheduling office.