Norton Children's Surgery Case Request

Today's date: _____

Location: ☐ Norton Children's Hospital ☐ Norton Children's Medical Center ☐ Norton Women's & Children's Hospital

Requesting surgeon:_____

Surgery date:_____ Surgery time:_____ Total surgery time (includes set up/turnover):_____

_____ _____ ☐ Female ☐ Male

Patient Name Patient DOB

Patient address: _____ Patient phone: _____

_____ Secondary phone:_____

City, State, Zip

Primary Insurance:_____ ID#_____

Secondary Insurance:_____ ID #_____

Anesthesia: ☐ Local ☐ General ☐ MAC

Bed type: ☐ Outpatient ☐ 23 hour observation ☐ Post-op admit ☐ Pre-op admit

Diagnosis:_____

Pertinent medical history:_____

Procedure location:
☐ Left ☐ Right ☐ Upper ☐ Lower ☐ Bilateral ☐ Lingual

Procedure:_____

Interpreter needed: ☐ No ☐ Yes If yes, Language: _____

Comments: _____

Office scheduler Name: _____

Office scheduler Phone:_____ Fax: _____

Please fax this completed form to pediatric surgery scheduling at (502)629-6350.