Surgery Posting FAX# 1-877-470-1270

□ Nash General □ Nash Day **Date/Time Posted:**_____

****Minimum Data Set (MDS) information indicated by Highlighted Box.**
Cases will NOT be posted without completed MDS

Patient:_____ **Phone Number:**_____

Cell number:_____ **Work Number:** _____

Name of Guardian/Caregiver/Nursing Home:_____

Social Security: _____ **Date of Birth:** _____**Gender:**_____

Patient Address: _____

County: _____ **Zip Code:** _____ **email:** _____

Patient Allergies: _____

Patient Precautions: _____

All Insurance Providers and number: _____
(primary and secondary)

_____

Authorization number: _____
(please include date range)

Surgery Date: _____**Case Order:**____**Pre Operative Dx:** _____
(description AND Dx code)

Patient Education Date requested: _____ **Phone** **Visit**

Surgeon:_____ **Assistant:** _____

Primary Procedure _____

Laterality_____**Right**_____**Left**_____**Bil**_____

Add'l Procedure: _____

Laterality: **Right** **Left** **Bil** **Uterine size:** _____

Encounter : _____**CPT Code:**_____

Special Equipment:
□ **Intra-Operative Monitoring** □ **Cell Saver** □ **C-arm**

Patient type: □ **outpatient (SDC/MOP)** □ **inpatient (IP/MIP)**

Other Equipment Not Listed Above: _____

Need Rep Contacted: ___**Yes**_____**No**____ **No. of Localization site(s):** ___**1**____**2**____

Breast Biopsy Patients: BCCCP Pt: Yes/No Recent Dx: Yes/No Implants: Yes/No

X-ray: Yes/No If Yes Where:_____ **Pt Needs Assistance Standing: Yes/No**