MERCY HEALTH
SAINT MARY'S

ORIGINAL REQUESTED SURGERY DATE: _____
FIRST NAME: _____LAST:_____ MI:__
DATE OF BIRTH: _____ GENDER: M ☐ F ☐

AMENDED SURGERY SCHEDULING REQUEST:

Fax to Centralized Scheduling @ 312-579-3450 when any changes are made after the original procedure-scheduling request sent.
If the change is made the day prior to the requested surgery date follow the prompts below:

- If change request is made **before Noon** the day prior to date of requested surgery directly call: 616-685-4000
- If change request is made **after Noon** the day prior to date of requested surgery directly call: 616-685-6440
- After call is made, fax amended form directly to OR desk at: 616-685-8960

SURGEON(S):

Original Admit Status: _____
New Admit Status : ☐ Surgery to the floor (Inpatient)
☐ Hospital Outpatient Surgery (Ambulatory Surgery) Planned discharge from hospital unit
☐ Hospital Outpatient Surgery (Ambulatory Surgery) Planned discharge from surgery unit

CHANGE IN TIME OR DATE

Original Date:_____ **New Date:**_____
Original Time:_____ **New Time:**_____
Original Estimated Length of Procedure:_____ **New Estimated Length of Procedure:**_____

CHANGE IN PERMIT/PROCEDURE

Permit to Read (No abbreviations allowed): Side? ☐ Right ☐ Left

Additional procedure information:
CPT Code:

CHANGE IN THE ANESTHESIA TYPE

Original Anesthesia Type:
New Anesthesia Type: ☐ Local ☐ MAC ☐ General ☐ Spinal ☐ Epidural ☐ Nerve Block (location):
☐ Anesthesia Other type:

CHANGE IN EQUIPMENT /SPECIAL REQUEST

ADDITIONAL ORDER(S)

CASE CANCELLATION : ☐ Cancel this Case ☐ Move Other Cases Up **Reason for Cancellation:** ☐ Patient Decision ☐ Change in clinical condition ☐ To be rescheduled at future date
☐ To be completed at another facility ☐ Other please specify:

Physician Signature: Date: Time:

Scheduler Contact Name/Phone Number: Date Faxed: