

KADLEC REGIONAL MEDICAL CENTER
888 SWIFT BLVD
RICHLAND WA. 99352
FAX 509-942-3108
SCHEDULING: 509-942-2684/2685

Operating Room Fax Scheduling Form

Today's Date: _____ Name of Person Completing Form: _____

Patient Name: _____ Date of Birth: _____ Sex: M F

Phone Number: _____ Cell: _____ Work: _____

Surgeon: _____ Date of Procedure: _____ Time: _____

Register Patient As: Inpatient ICU Outpatient Procedure CDU up to 23hrs
 Bloodless Program Allergies: _____

Procedure on Consent: *(Reminder: Autologus product requests must on consent and schedule):* _____

Length of Procedure: _____ Right Left Bilateral

Anesthesia Type : General Mac AOC Local Other

Special Requests *(implants, supplies, equipment, autologus product request):* _____

New products must go through an approval process guided by our value management team.

Vendor Notified: YES NO Representative present for surgery: YES NO

Please fax completed form to 509-942-3108