



ABR UNDER ANESTHESIA SCHEDULING FORM

Referring Provider: _____

Office phone number: _____ Office contact person: _____ BT Scheduler: _____

Patient name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____

Parents/Legal guardian: _____ Relationship to patient: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Diagnosis with ICD-10 codes: _____

Procedure: Auditory Brainstem Response Testing (ABR) under general anesthesia, possible ear mold impressions, possible tympanogram

Admission type: ☐ Same Day Surgery

Preferred language for healthcare: _____ Interpreter (including sign) needed: ☐ Yes ☐ No

History & Physical to be completed by: ☐ PCP – Name: _____ Phone: _____

Specific patient, procedure or treatment needs: _____

Insurance Coverage (please fax copy of card): _____

Subscriber: _____ Subscriber Date of Birth: _____

Employer: _____ Policy # _____ Group # _____

Benefits & Eligibility Phone # _____

Initiate orders per ABR preferences

Initiate anesthesia protocol (Anesthesiology will obtain informed consent for the anesthesia)

Physician Signature

Date

Time

EMAIL COMPLETED SHEET TO surgery.scheduling@boystown.org or FAX: 531-355-0012 QUESTIONS, CALL: 531-355-7799