

## General Surgery Appointment Request Form

Today's date: \_\_\_\_\_

**Patient Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **MI** \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  Female  Male

Address: \_\_\_\_\_ City, ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Primary language: \_\_\_\_\_ Interpreter needed:  Yes  No Specify language: \_\_\_\_\_

Guardian/ POA: Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Effective date: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

ID #: \_\_\_\_\_ GR #: \_\_\_\_\_

**Referring Provider:** \_\_\_\_\_

Office phone: \_\_\_\_\_ Office fax: \_\_\_\_\_

Address: \_\_\_\_\_

PCP (if different from above): \_\_\_\_\_

**Office Consultation** for: \_\_\_\_\_

First available (1-3 weeks)  **Urgent (1-5 days)** **Same day appoints require provider-to-provider phone call**

Lesion removal  Worker's comp  D.O.I. \_\_\_\_\_

### Testing done:

MRI  CT  Mammo  U.S.  PET

BaE  Labs  EGD  CLP  Other: \_\_\_\_\_

Facility: \_\_\_\_\_

**Please FAX ALL test reports, pertinent office notes and medication list to (603) 577-4354.**

### Surgical Consults:

Abdominal pain

Breast  
     Abn mammo: \_\_\_\_\_  
     Lump: \_\_\_\_\_  
     Other: \_\_\_\_\_

Hernia

Hemorrhoids

Pilonidal cyst

Rectal pain

Vasectomy

Wound care. Location: \_\_\_\_\_

### Lesion Removal:

**Consult required first for hand, face, or any lesion > 2 cm.**

Type (i.e. nevus, lipoma): \_\_\_\_\_

Location: \_\_\_\_\_

Size: \_\_\_\_\_

Single

Multiple – how many? \_\_\_\_\_

Allergic to Xylocaine:  Yes  No

Taking:  Coumadin  Plavix  Aspirin  NSAIDS

May stop 5 days prior to procedure:  Yes  No