



# Saint Vincent Catholic Medical Centers

## Cardiac Catheterization Lab & EP Booking Form

<b>Fax:</b>	<b>212-604-3802</b>
<b>Phone:</b>	<b>212-604-2234</b>

*“\*” Fields are **required** as they are key data elements to initiate pre-registration.  
Complete other fields when information is available.*

<b>Patient Name*:</b> _____		<b>Sex*:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<small>Last</small>	<small>First</small>		
<b>Date of Birth*:</b>	<b>SSN*:</b>	<b>MRN:</b>	
<b>Patient Address*:</b>			
<b>Home / Work / Cell Telephone #*:</b>			
Guarantor / Legal Guardian:		Best Time to Call:	
Employer:		Employer Phone:	
Interpreter Needed:		Language:	
Emergency Contact:	Tel #:	Relationship:	
<b>PROCEDURE</b>			
<b>Referring Physician*:</b>		Tel #:	Fax #:
Surgeon's Name:		Tel #:	Fax #:
Schedule Date:	Surgery Time:	Time Req:	min/hr
Procedure(s):		CPT Code:	
		CPT Code:	CPT Code:
		CPT Code:	CPT Code:
Anesthesia: <input type="checkbox"/> Local <input type="checkbox"/> Standby <input type="checkbox"/> General			
<b>Diagnosis*:</b>		<b>ICD9*:</b>	
PAT (within 3 – 7 days) <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:	Time:
<b>INSURANCE</b>			
<b>Insurance Company*:</b>			
<b>Policy #*:</b>	Group #:	Ins. Tel #:	
<b>Subscriber Name*:</b>	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Subscriber SSN:			
Secondary Ins:	Policy #:	Ins. Tel #:	
Subscriber Name:	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
<b>Pre-Cert # if Applicable*:</b>			
Name of person at Ins. Company issuing Pre-Cert:		Tel #:	Date obtained:
<b>DATE FAXED</b>			
Date Faxed:		By:	