



Rahil Malik MD, Fellow of American College of Obstetrics and Gynecology

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www.DavieObGyn.com

Dear patient:

As part of our effort to provide exceptional medical care, your physician, Dr. Malik, has determined that a surgical intervention is required for Diagnostic and/or Therapeutic purposes.

For us to provide this care we will make an effort to coordinate care to ensure that we have the right instruments, medications, anesthesia options and laboratory testing available for specimen processing. This would allow your procedure to be done in the office or if needed, at the hospital.

If your surgery is scheduled in the hospital, we would need to arrange and book appropriate period of time in a specialized operative suite with anesthesia and nursing personnel. We will also coordinate with your insurance company to identify your out-of-pocket costs for the surgical component for our office. Many individuals and significant time are devoted to getting authorization for your surgical needs

We require a **non-refundable \$150 deposit** in order to process this surgical request and once the surgery is completed, **this would be applied towards your surgical fee**. If you decide not to pursue surgical interventions or decide to cancel surgery, this would not be refunded.

We appreciate your cooperation in helping you with this process.

Dr. Malik

Name

Tel

Insurance

Diagnosis

Procedure

CPT

Patient Name: _____ AGE: _____

Patient phone # _____

Insurance Name: _____

Dx: (1) _____

Insurance phone# _____

Dx: (2) _____

Insurance ID: _____

Dx: (3) _____

Inpatient _____ Outpatient _____ In-office _____ Procedure Day: ____/____/____

Procedure 1: _____ CPT _____ Profile _____

Procedure 2: _____ CPT _____ Profile _____

Need authorization: Yes: _____ # _____

NO: _____ Ref. or Conf. # _____

Need referral: Yes: _____ PCP Name: _____ PCP PH # _____

No: _____ Ref. or Conf. # _____

Co-Pay: _____

Co-Insurance: _____

Deductible: \$ _____ Met: \$ _____ Left: \$ _____

Max out of pocket \$ _____ Met: \$ _____ Left: \$ _____

More than \$50 deductible Patient must pay Deposit of \$ _____ See Office
manager

PATIENT CURRENT BALANCE \$ _____

<u>Check By</u>	<u>Date Check</u>	<u>Spoke With</u>

WESTSIDE REGIONAL MEDICAL CENTER

FAX COMPLETED FORM TO: E-FAX 954-370-4497

Surgical Scheduling Line: 954-916-5445

INPATIENT RM # ☐ OUTPATIENT ☐ SDA (same day admit) ☐ 23 hr ☐

DATE OF SURGERY _____ TIME: _____ Language: _____

SURGEON: Dr Malik OFFICE NUMBER: 954-880-1010

PATIENT NAME: _____ SURGICAL ASSIST
NEEDED

CELL#: _____

PRIMARY INS: _____ ID#: _____

SECONDARY INS: _____ GROUP: _____

INSURANCE AUTHORIZATION # _____ MEDICATIONS _____

OPERATION: _____

any other indicated procedures _____

CPT CODE: _____

DIAGNOSIS: _____

LABS: ☒ CBC ☒ CHEM PT PTT UA C&S TYPE & SCREEN ESR HEMOGLOBIN A1C URINE HCG

☐ SSEP/ NERVE MONITORING
☐ C-Arm

☐
☐ Perfusion Cell Saver
VIP/ERAS

☐
☐ Microscope
ERSA-JET

☐ Laser
Other
☐

PRE-OPERATIVE ANTIOTOBICS _____ ANCEF 2 G IV PREOP (unless allergic!)

MEDICAL CLEARANCE BY: _____

CARDIAC CLEARANCE BY: _____

*VENDOR: _____ IMPLANTS/INSTRUMENTATION: _____

SPECIAL REQUESTS: _____

ANESTHESIA: MAC LOCAL SPINAL ☒ GENERAL PERSON BOOKING

CASE: Malik _____

SIGNATURE _____ DATE: _____ TIME: _____

SURGEON: Dr MALIK

SURGEON PHONE NUMBER: 954-880-1010

SURGERY DATE: _____

SURGERY TIME: _____ OR MINUTES: _____

PRE-OP APPT DATE & TIME: _____

Central Scheduling Department (877) 331-7032

HCA Florida

University Hospital

SCHEDULING FAX: 954-694-9815
SCHEDULING OFFICE: 954-475-5737

ANESTHESIA QUESTIONNAIRE AND

Copy of Insurance Card and driver's license/ government issued
identification (front & Back) MUST BE FAXED WITH BOOKING

TYPE OF ADMISSION: _____ OUTPATIENT _____ 23 HOUR OBS _____ INPATIENT SURGERY

PATIENT'S LEGAL NAME: _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT# _____

INSURANCE _____

☐ HMO ☐ PPO ☐ OTHER _____

SUBSCRIBER NAME: _____

POLICY# _____ GROUP# _____

INSURANCE AUTHORIZATION# _____

OBTAIN CONSENT FOR (PROCEDURE) _____

CPT CODE _____ CPT CODE: _____ CPT CODE: _____ CPT CODE: _____ CPT CODE: _____

PREOPERATIVE DIAGNOSIS _____

SPECIAL EQUIPMENT /REQUEST: _____

MEDICAL DEVICE REPRESENTATIVE INFORMATION: _____

ANESTHESIA TYPE _____ **ANEST CHOICE** _____ **GENERAL** _____ **SPINAL** _____ **MAC** _____ **LOCAL** _____ **BLOCK PRE/POST X**

ALLERGIES

PATIENT WEIGHT: _____ BMI: _____

ENHANCED SURGICAL RECOVERY PREOP MEDICATIONS ORDERS PER ANESTH ☐ YES ☒ NO

PREOPERATIVE TESTING & LABS

☐ NO LABS REQUIRED

☐ CBC

☐ PT/INR

☐ U/ A AND CULTURE

☐ LABS PER ANESTHESIA GUIDELINES

☐ H&H

☐ HCG

☐ SCIO

☐ COVID 19

☐ CHEM 12

☐ EKG

☐ OTHER _____

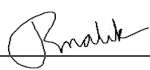
☒ TYPE & SCREEN

☐ CXR

PRE-OPERATIVE ANTIBIOTICS: ANCEF 2 g IV

MEDICAL CLEARANCE BY (PCP): _____ PHONE NO: _____

CARDIAC CLEARANCE BY (PCP): _____ PHONE NO: _____

SURGEON SIGNATURE:  DATE 7 } TIME _____

Surgeon NAME PRINTED (BLOCK LETTERS-HANDWRITTEN) RAHIL MALIK MD