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

5599 S University Drive, suite 305, Davie, Florida, 33328
Tel: 954-880-1010 Fax: 866-531-7689
www.DavieObGyn.com

Dear patient: BELLSMYTHE, Milly • Jan 31, 1968

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	BELLSMYTHE, Milly • Jan 31, 1968
Tel	954-997-2368
Insurance	OSCAR
Diagnosis	n95.0
Procedure	Hysteroscopy D&C
CPT	58558

BELLSMYTHE, Milly • Jan 31, 1968

Patient Name:_____**AGE:**___

Patient phone # 954-997-2368

Insurance Name: OSCAR **Dx: (1)** n95.0

Insurance phone#_____ **Dx: (2)**_____

Insurance ID:_____ **Dx: (3)**_____

Inpatient☐ **Outpatient**☑ **In-office**☐ **Procedure Day:** _____/____/_____

Procedure 1: Hysteroscopy D&C **CPT** 58558 **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$_____

Check By	Date Check	Spoke With

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

BELLSMYTHE, Milly • Jan 31, 1968

PATIENT NAME: _____ SURGICAL ASSIST NEEDED ☐

CELL#: 954-997-2368

PRIMARYINS: OSCAR **ID#:** _____

SECONDARY INS: _____ **GROUP:**

INSURANCE AUTHORIZATION # _____ **MEDICATIONS** _____

OPERATION: Hysteroscopy D&C

any other indicated procedures

CPT CODE: 58558

DIAGNOSIS: n95.0

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

☐ **SSEP/ NERVE MONITORING** ☐ **Perfusion Cell Saver** ☐ **Microscope** ☐ **Laser**
☐ **C-Arm** **VIP/ERAS** **ERSA-JET** ☐ **Other**

_____

PRE-OPERATIVE ANTIOBOTICS 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: _____ _____

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

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

PATIENT'S LEGAL NAME: BELLSMYTHE, Milly • Jan 31, 1968

954-997-2368

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

EMERGENCY CONTACT NAME: EMERGENCY CONTACT#_____

INSURANCE OSCAR ☐ HMO ☐ PPO ☐ OTHER _____

SUBSCRIBER NAME: _____

POLICY#_____GROUP#_____

INSURANCE AUTHORIZATION#_____

OBTAIN CONSENT FOR (PROCEDURE) Hysteroscopy D&C

CPT CODE 58558 CPT CODE:___ CPT CODE: CPT CODE: CPT CODE:_____

PREOPERATIVE DIAGNOSIS n95.0

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
☐ LABS PER ANESTHESIA GUIDELINES
☐ COVID 19
☑ TYPE & SCREEN
☑ CBC
☐ H&H
☑ CHEM 12
☐ PT/INR
☐ HCG
☐ EKG
☐ CXR
☐ U/A AND CULTURE
☐ SCIO
☐ OTHER_____

PRE-OPERATIVE ANTIBIOTICS: ANCEF 2 g IV

MEDICAL CLEARANCE BY (PCP):_____PHONE NO:_____

CARDIAC CLEARANCE BY (PCP): PHONE NO:_____

SURGEON SIGNATURE:_____DATE _____ TIME_____

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