

**CSH Pre-Admission Orders /Admission Schedule**



1306 Kanawha Blvd. East Charleston WV, 25301

304-343-4371

**Instructions: Please provide as much information as possible.  
Fax this document and a copy of the patient's insurance card (front & back) to 304-353-0329.**

Physician:		Time of Arrival:	
Date of Surgery:		Type of service:	
Referring Physician (Full Name):		Ref Physician Phone:	Fax:
Physician's Office Notification Email:			
Last Name: Maiden Name:		Patient's Social Security #:	
First Name: MI:		DOB:	
Mailing Address:		Age:	
City:	State:	Zip Code:	Gender: Male Female
Home Phone:			
Work Phone:	Cell Phone:	E-Mail Address:	
<b>Latex allergy?</b>		<b>Anesthesia Type:</b>	
<b>History of MRSA?</b> Yes No			
Surgical Procedure Description:			
Please indicate:			
Surgical Procedure Code: (CPT-4)			
Admitting Diagnosis (no abbreviations please):			
Admitting Diagnosis ICD-9/ICD-10 Code:			
Is there any Testing or Antibiotics Needed on Admission: (If Yes please list here):			
<b>Pre-Admitting Testing Orders: (check all needed)</b> CBC PTT PT BMP CMP H&H EKG			
Additional Orders:			
PAT (scheduled) Date:		Time:	
Imaging Type:	X-Ray MRI	Ultrasound Other	Body Part Being Imaged:
<b>Type of Insurance</b>		<b>Insurance ID#</b>	
Secondary Type of Insurance		Secondary Insurance ID#	
Authorization Number		Insurance Rep Name	
Reference Number			
PACKET CHECKLIST:		H&P	Insurance Card Drivers License
<b>CSH INTERNAL USE ONLY:</b> Patient Account #:			

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_