REFERRAL/SCHEDULING CHECKLIST

DOS REQUESTED:_____/_______/___________

PATIENT LEGAL NAME:____
PATIENT PREFERRED NAME:____
PATIENT DOB:_____/_______/_____________
NUMBER OF PAGES ATTACHED: ____________
DOES THIS SERVICE REQUIRE AUTH? Y/N (If so, please attach a copy of the auth letter)

AUTH #: ____

✓	***THE FOLLOWING ITEMS MUST BE INCLUDED IN THIS PACKET TO BEGIN THE SCHEDULING PROCESS:**
	COMPLETED BOOKING SHEET
	LEGIBLE DEMOGRAPHICS (INCLUDING PATIENT'S LEGAL IDENTIFICATION AND INSURANCE CARD). ***If you are not able to forward the insurance card, please send the insurance name and ID.
	COMPLETED PRIOR AUTHORIZATION BY CLINIC
	SIGNED PAT/DIAGNOSTIC TESTING ORDERS (INCLUDING CPTS AND ICD-10 DX) (ORDERS ARE VALID FOR 90 DAYS)
	OFFICE NOTES (INCLUDING MED NEC FOR ORDERED TESTING AND PROCEDURES)
	IN ORDER TO EXPEDITE THE CLEARANCE PROCESS, IF YOU HAVE A MEDICATION LIST, OR ANY OUTSIDE RECORDS ON A PATIENT (LABS, CARDIAC, NEPHROLOGY, PULMONOLOGY, ETC) PLEASE INCLUDE THESE IN THE BOOKING PACKET.
*	**THE FOLLOWING ITEMS MUST BE SENT TO US PRIOR TO PATIENT'S SURGICAL DATE:**
	SIGNED H&P PRIOR TO SURGICAL DATE (MUST BE WITHIN 30 DAYS OF SURG OR 24 HRS OF ADM)
	SIGNED PRE-OP ORDERS PRIOR TO SURGICAL DATE

****If any of the above line items do not apply, please mark N/A***

COMMENTS (SMC Internal Use Only)

	Inpatient Only List Reviewed
	Medicare Outpatient Authorization List Reviewed

DATE RECEIVED: ______/_____/__________
DATE REVIEWED: _____/_____/__________
REVIEWER: __________________________

v2 3/7/2023

***Please fax completed form with all required documentation to SMC Scheduling at 307.215.0750