Patient Reservation Form Part A

PATIENT

MEDICAL RECORD NUMBER				
NAME (LAST, FIRST, MIDDLE)			MOTHER'S MAIDEN NAME	
BIRTHDATE	SEX	LANGUAGE	PREVIOUS NAMES	
SOCIAL SECURITY NO.			RELIGION	
ADDRESS				

CITY	STATE	ZIP	DAY PHONE	EVENING PHONE	EMAIL ADDRESS

ADMISSION

ADMIT DATE	PROCEDURE DATE	CALL FOR PRE-SEP APPOINTMENT: DATE_____________ TIME_____________ H&P: DATE_____________ TIME_____________

DIAGNOSIS EXPLAINING ADMISSION (PLEASE DO NOT ABBREVIATE)

TREATMENT PLAN (SPECIFY ANTICAPED MEDICAL OR SURGICAL PROCEDURE)

ADMISSION TYPE	THE ADMISSION DECISION WAS MADE AT:
☐ ROUTN/ELECTIVE ☐ URGENT ☐ ER	☐ EMERGENCY ☐ PRIVATE PRACTICE ☐ UC CLINIC____ ☐ OTHER HOSPITAL ☐ OTHER SKILLED FACILITY

SERVICE	LENGTH OF STAY	☐ OUTPATIENT	NURSING UNIT	PVT RM REQUESTED
	DAYS___________	☐ OUTPATIENT BED STATUS		☐ ISLOATION ☐ PATIENT REQ.

PHYSICIAN

ADMISSION CODE	ADMIT NO. NAME			
ATTENDING MD CODE	ATTENDING MD NAME			
REGULAR MD CODE	REGULAR MD NAME			
ADDRESS	CITY	STATE	ZIP	DAY PHONE: ( )
REFERRING MD CODE	REFERRING MD NAME			
ADDRESS	CITY	STATE	ZIP	DAY PHONE: ( )
TRANSFERRING FACILITY	CITY	STATE	ZIP	DAY PHONE: ( )

DATE OF ADMISSION	CONTACT PERSON	PHONE: ( )	AMBULANCE: ☐ YES ☐ NO	ETA

INSURANCE

☐ SELF PAY- PLEASE CONTACT THE FINANCIAL COUNSELING OFFICE FOR FINANCIAL ARRANGEMENTS (415) 353-1966

☐ MEDICARE ☐ MEDICARE PART B ONLY ☐ MEDI-CAL ☐ CCS ☐ PRIVATE INSURANCE ☐ BUDGET RESEARCH ☐ WORKERS' COMP

	PRIMARY	SECONDARY
INS. CO.	__________	__________
ADDRESS:	__________	__________
SUBS. NAME:	__________	__________
GRP. NAME	__________	__________
POLICY #:	__________	__________
SS#:	__________	__________
AUTH INFO:	__________	__________

RESEARCH	
ZZ#:	__________
CHR/RB APPROVAL #:	__________
CONTACT NAME:	__________
BOX #:	__________
PHONE #:	__________

IF PATIENT'S INSURANCE COVERAGE IS INVOLVED, COMPLETE PART B. AVAILABLE ON-LINE AT: HTTP:\WWW.SOM.UCSF.EDUSOMRESEARCH\ CLINICAL.RESEARCHRESEOURCESMANUAL.HTM

NAME/PHONE OF CALLER:____ ☐ INTAKE ☐ PRE-REG