Huntington Hospital

SURGERY SCHEDULING CHANGE/CANCELLATION REQUEST

Original Confirmation #: _____   **Currently Scheduled on (date):** _____

Last Name: _____

First Name: _____   **M.I.** ____

Surgeon: _____

REVISION:

New Surgery Date: _____   **Time:** _____

In My Block Time ☐

Reserved Time With: _____ **On:** _____   (I understand this
expires in 72 hrs.)
(Who you spoke with)   (Date)

Same Procedure ☐

Change in Procedure

(Exactly as it will be on consent)

_____

_____

_____

_____

CPT Code Change: _____   **No Change** ☐

Change in Diagnosis: _____   **No Change** ☐

ICD9 Change: _____   **No Change** ☐

CANCELLATION:

Reason: _____
(Pt, MD, Equipment, Others)

Requested By: _____

Fax No: _____

Comments: _____

******** Call Center Use Only ********	******** OR Schedule Use Only ********
Date: _____ Time: _____ Init: _____	Confirmation # _____ Changed by: ____
MR# _____ Faxed: _____	Date: _____ Time: _____ Faxed: _____ Init: _____
V#: _____	

=======PLEASE FAX CHANGE REQUEST TO (626) 397-3592 =======