CAROLINA ASC

Excellence in Outpatient Surgery

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Please check one of the following:

☐ Ultrasound Exam ☐ Surgery ☐ Consult

Patient Name: _____

Date of Birth: _____

Dialysis Days: _____

Order/Reason (please list side if applicable): _____

_____

_____

Referring Provider: _____

Please include the following information:

- Face sheet/patient demographics
- Both sides of insurance card
- Pertinent office notes
- Allergies/list of current medications