UCLA Health System

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NON-SURGICAL ADMISSION REQUEST

ID Number: Name: Date of Birth: Age: Sex:	**Admit Date:** **Time:** **Estimated LOS:** ☐ Admit Date same as Pre-Op Visit Date? Facility: Admission Status:

Isolation Required: ☐ Yes ☐ No ☐ Unk

Clinical Trial/Research: ☐ Yes ☐ No

Diagnosis/Co-Morbidities:

Treatment Plan:

Additional Clinical Information - Vitals: BP: / HR: Temp: RR: O2 Sat:

EKG Changes: Abnormal Lab Results:

X-Ray Results:

CT Scan Results:

Referral Source:

Source Name:

Patient Location & Contact Information:

Referral Type: Service:

Level of Care: Team:

Admitting MD: Pager: Phone Number: ( )

Referring MD: Pager: Phone Number: ( )

Any special procedures? ☐ Yes ☐ No

Special Needs: ☐ Yes ☐ No

Transplant Status:

INSURANCE AUTHORIZATION

Cash Account: ☐ Yes ☐ No HMO Account: ☐ Yes ☐ No

Medicare #: Medical #:

CCS #: CCS HMO: ☐ Yes ☐ No

Insurance Name: ID #: Group #:

Review Agency: Phone Number: ( )

Scheduled by: Deirdre Apablasa Pager: Phone Number: ( )

Today's Date: 07/25/2017 Time: 17:09:25 Location:

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