Baylor Medical Center at Frisco

Surgery Cancellation/Reschedule Form

Fax: 214-618-2095

Date of Surgery____________________________________

Time of Procedure__________________________________

Patient Name______________________________________

Surgeon____

Surgical Procedure__________________________________

____

Reason for Cancellation______________________________

____

Rescheduling Date__________________________________

Person Canceling___________________________________

Date and Time of Call_______________ Initials___________

Received by________________ Date & Time Received_______

For scheduler's use only

*Please notify the following departments when you add a case. Thank You!

_____Dir. Of Surgery _____Pre-Op _____PACU _____Admitting

Notified by:_________________________ Time:______________