WOMEN'S HEALTH CONNECTION (WHC) SURGERY / PROCEDURE REQUEST FORM

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

***Schedule the surgery/procedure only after you receive the processed referral from WHC.**

PATIENT INFORMATION		
Name:	DOB (mm/dd/yyyy):	Today's date (mm/dd/yyyy):

SURGERY INFORMATION	
Surgeon:	
Name of facility/surgery center:	Expected date of surgery (mm/dd/yyyy):
Name of surgery/procedure:	
CPT Codes:	☐ Global period Days: ☐ No global period
Reason for surgery/procedure:	
WHC Anesthesia Group CPT Code:	Length of surgery:
Pre-operative testing CPT Codes:	
WHC Pathology Provider:	

PROVIDER OFFICE INFORMATION	
Requesting clinician:	Phone:
Clinician signature:	

PLEASE FAX COMPLETED FORM TO 775-284-1918 FOR WHC APPROVAL	
Attention to:	☐ Approved ☐ Denied
Care Coordinator:	Date (mm/dd/yyyy):
Registered Nurse:	Date (mm/dd/yyyy):
I, the undersigned, do attest that the above information is accurate and the above surgery/procedure conforms to the standard of care and is in compliance with the policies and procedures of the Women's Health Connection program. State ID#:	

This publication is supported by the Nevada State Division of Public and Behavioral Health (DPBH) through grant number NU58DP007102-05-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the DPBH or CDC.