Hackensack Meridian *Health*
Jersey Shore University Medical Center

Attachment A

REQUEST FOR SUGICAL BLOCK TIME

Surgeon (individual block): _____ Group block:_____ Specialty block: _____

Date Request Submitted: _____

Office (Name & phone): _____

Surgeon (Name & phone): _____Signature_____

Contact email: _____

	Weekday	Week 1	Week 2	Week 3	Week 4	Week 5	Block Time Requesting	Main OR	ASC
1st Choice									
2nd Choice									
3rd Choice									

Projected Volume: _____ In-pt. %_____ Out-pt. %_____

Attach a list of typical procedures

Indicate below "Typical Equipment" needs:

	C-arm / O-arm			Laparoscopic Video Equipment
	Microscope			Hysteroscopy
	Brain Lab			DaVinci Robot
	OR Table:			Special Instrumentation:
	Other:			Other:

Form must be completed in its entirety for consideration.

Submit request to: **Olidia Grasso, Secretary**
Perioperative Services
Administrative Office, Ackerman 4 North

Olidia.grasso@hackensackmeridian.org
Phone: (732) 776-4532
Fax: (732) 776-4550