OVER-AGE REQUEST

Le Bonheur Children's Hospital

Physician:_____ **Date:**_____

Physician's Fax#: _____

Physician's Telephone:_____

Patient's Name_____ **DOB:** _____

Weight:_____ **(patient's weight MUST be provided BEFORE this request will be processed)**

Sex: M◯ F◯ (please circle) **Date of Procedure**_____

Procedure:_____
Reason for Request:_____
Insurance:_____
Contact Person:_____ **Phone**_____

Anesthesiologist:_____ **Date**_____

Approved / Denied (Please circle) **Comments**_____

Medical Director **APPROVED◯ DENIED◯ (please circle)**

Comments:_____

_____ _____
Medical Director's Signature **Date**

ADMINISTRATIVE USE ONLY
The following have been notified of Medical Director's approval

287-5102 (anesthesiology) **266-6423 (surgery scheduling)** **937-3335 (patient access computer)**

Notification by_____ _____
Executive Assistant Signature **Date**

FAX: (901) 287-5956

Office: 287-5961