

Appt Date: _____
Time: _____

To Schedule, fax form to 215-453-4436. For information call 215-453-4269.

Ordering Physician's Signature/Name: _____

CC Physician: _____

GI Procedures

- EGD
- Colonoscopy
- ERCP
- PEG Tube Insertion
- PEG Tube Change
- Sigmoidoscopy

Pulmonary Procedures

- Bronchoscopy
- Bronchoscopy with fluoro
- MRI under sedation (if no EKG within 6 months- order EKG)

Infusion center - see attached orders

- Lumbar puncture
- Thoracentesis
- Paracentesis
- s/p paracentesis infusion of Albumin (send order)

PLEASE INDICATE STENT OR PEG TYPE AND SIZE FOR ALL ERCP OR PEG TUBES

NSS 500 ml @ 25 ml/hr (KVO) for all Endoscopic GI Procedures. Begin infusion pre-procedure.

ANESTHESIA TYPE - please complete for all GI and Pulmonary Procedures

- TIVA Conscious Sedation Local None General

DEMOGRAPHICS

Last Name: _____ First Name: _____ M. I. _____

DOB: _____ Age: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Preference 1: _____ Phone Preference 2: _____

If Child, Mother's Name: _____ DOB: _____ Phone: _____

If Child, Father's Name: _____ DOB: _____ Phone: _____

Patient has POA - Name: _____ POA Relationship: _____ Phone: _____

SPECIAL NEEDS Check if appropriate:

- Interpreter Needed - Language: _____
- MRSA
- POA
- Physically challenged
- Mentally challenged

REGISTRATION INFORMATION Classification Admit SDC

Diagnosis: _____

Diagnosis Code(s): _____ CPT Code(s): _____

Ordering Physician(s): _____ Family Physician: _____ Referring Physician: _____

INSURANCE INFORMATION Precert # _____ Approved LOS: _____

Insurer	Group #	ID #	Subscriber Name	Subscriber Employer
Primary Name				
Secondary Insurer				

LABS ON ADMIT / OTHER

EKG if not within 6 months of MRI

Physician Signature _____ Date _____ Time _____

