

SPU RESERVATION FORM
NON SURGICAL PROCEDURES

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

Infusion center -

see attached orders

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

Pulmonary Procedures

- ☐ Bronchoscopy
☐ Bronchoscopy with flouro

☐ MRI under sedation (if no EKG within 6 months- order EKG)

☐ Laryngoscopy

☐ Other _____

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: _____

ALLERGIES

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 _____

