GVH GRAND VIEW HEALTH

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
- ☐ Sígmoídoscopy

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

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Physician Signature ________________________________ **Date** ____________ **Time** ____________