GI SCHEDULING FORM

Fax# 818.902.5138 email:GIscheduling@valleypres.org

Date of Procedure:_____ Requested Time:_____ Length:_____

Last Name: _____ First Name _____

Date of Birth:_____ Gender: ☐ Male ☐ Female Social Security #:_____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Allergies _____ HT _____ WT _____

Address:_____City_____State ____ZipCode_____

Phone Number (Primary): _____Alternate Phone _____

Parent/Guardian/Facility Name:_____

Proceduralist: _____Request: ☐ Yes ☐ No Assistant: _____

Procedure: ☐ EGD ☐ Colonoscopy ☐ Peg Placement ☐ ERCP ☐ Flexible Sigmoidoscopy

Diagnosis: _____

ICD-10 _____ CPT Code _____

☐Blood Transfusion schedule day of Procedure ☐ Bronchoscopy (performed in OR) ☐ Other_____

Anesthesia Type: ☐ MAC ☐Moderate Sedation ☐ Other _____

Comorbidities: ☐None ☐Cardiac/Vascular Disease/Hypertension ☐ Endocrine/Diabetes/Thyroid Disease
☐ Respiratory Disease (Smoker/Sleep Apnea) ☐ Kidney Disease ☐ Liver Disease

☐ Neurologic Diseas ☐ Hematologic/Bleeding Disorders

Insurance Name _____Policy Number _____

Insurance Type: ☐ HMO ☐ PPO ☐ MediCare ☐ MediCal

If **HMO IPA** Name _____**Days Approved:** _____

Authorization Number: _____☐ N/A Exp. Date_____

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back)

Special Equipment (Implants/Hardware): ☐ None

_____

Vendor/Rep ☐ None _____

Tel:_____ Email:_____

VALLEY PRESBYTERIAN HOSPITAL