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