



Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____
Street City State Zip Code

Home Phone #: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - DTC GI Lab

EGD EGD/PEG Colonoscopy ERCP EGD w/ Bravo EGD w/EUS Sm. Bowel Enteroscopy
 Flexible Sigmoidoscopy Other _____ Bronchoscopy Fluoroscopy Respiratory Isolation

Date of Procedure: _____ Time of Procedure: _____

Diagnosis: _____ ICD-CM Code: _____ CPT Code: _____

Medications prior to procedure:

- Ancef 1 gm IV x 1
- Ampicillin 2 gm IV x 1
- Gentamicin 80 mg IV x 1
- Vancomycin 1 gm IV x 1
- Other _____
- Cipro 400 mg IV x 1
- Zosyn 3.375 gm IV x 1
- Have patient sniff Lidocaine jelly 2% just prior to procedure
- Aerosol treatment with Lidocaine 4% solution

Labs: CBC PT PTT Other _____

Other diagnostic studies: _____

Orders generally followed for every patient:

- NPO
- IV Moderate Sedation Other _____
- Accucheck if patient is diabetic
- Start IV in right arm if possible (May use numbing spray when starting IV for patient comfort)
- IVFs:
 - a. For non-diabetic patients start 500 ml D5 0.45NS at KVO rate
 - b. For diabetic patients with blood sugar < 140 start 500 ml D5 0.45NS at KVO rate
 - c. For diabetic patients with blood sugar > 140 start 500 ml 0.45NS at KVO rate
 - Other: _____
- Notify MD if:
 - a. Bowel prep not taken as directed (includes medication and enemas)
 - b. Patient taking steroids, anticoagulants, or ASA
 - c. History-MVP, valvular disease, valve/hip replacement, implanted pacemaker/defibrillator etc.
 - d. Patient has anything by mouth within three hours
 - e. Blood sugar is > 200
 - f. Patient does not have appropriate transportation home

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License #: _____
 Physician Address: _____ Phone #: _____ Fax #: _____

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____