

**REAGAN STREET SURGERY CENTER**  
**SCHEDULING FAX FORM FOR GI LAB PROCEDURES**  
**Phone # 562-596-3140 Fax # 562-596-3142**

Physician \_\_\_\_\_ Procedure Date: \_\_\_\_\_ Procedure Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: M F

Patient's Address: \_\_\_\_\_

Subscribers Name if different than patient: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_ Phone # \_\_\_\_\_ cell /wk /other

Insurance Information \_\_\_\_\_ (please send copy of Ins card/demographics)

Subscribers Name if different than patient: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to patient:  Parent  Spouse  Other

(If insurance carrier is Workers Comp, please send Adjusters name, phone # and date of injury)

ID# \_\_\_\_\_ Group# \_\_\_\_\_ Ins phone # \_\_\_\_\_

Diagnosis: \_\_\_\_\_ (When scheduling lesion removal include the lesion size)

CPT Code: \_\_\_\_\_ ICD9: \_\_\_\_\_

Length of procedure \_\_\_\_\_ Equipment/supplies needed please describe \_\_\_\_\_

Referring Physician and Fax #: \_\_\_\_\_

<b>Pre Procedure Physician Orders</b>		
Obtain Consent to read:		
<input type="checkbox"/> Esophagogastroduodenoscopy with possible biopsy		
<input type="checkbox"/> Esophageal dilatation		
<input type="checkbox"/> Flexible Sigmoidoscopy with possible biopsy and/or polypectomy		
<input type="checkbox"/> Colonoscopy with possible biopsy and/or polypectomy		
<input type="checkbox"/> Nothing by mouth		
<input type="checkbox"/> Start IV using 1,000 ml Lactated Ringers <input type="checkbox"/> Saline Lock		
<input type="checkbox"/> Sedation medication to be ordered by physician		
<input type="checkbox"/> Other:		
<b>Physician signature:</b>	<b>Date:</b>	<b>Time:</b>
Orders Noted by RN/LVN: _____	<b>Date:</b>	<b>Time:</b>

ALLERGIES: \_\_\_\_\_

LATEX ALLERGY -YES OR NO

LATEX SENSITIVITY- YES OR NO

ANESTHESIA TYPE: LOCAL / MAC / GENERAL / IV SEDATION / CONSCIOUS SEDATION

Completed and faxed by \_\_\_\_\_ Phone # \_\_\_\_\_

