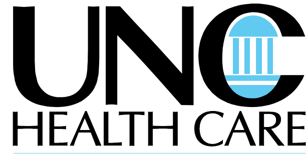


UNC HealthCare GI Procedure Request Form

Procedures will not be scheduled without insurance information.

NOTES

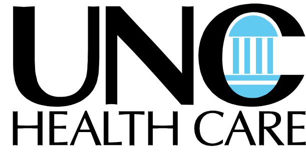
1. Antiplatelet agents such as aspirin, ticlopidine (Ticlid), clopidogrel (Plavix), etc should be stopped 5 days before the procedure, if it is safe to do so.
2. Warfarin should be stopped far enough in advance (usually 5-7 days) to allow the INR to decrease to < 1.5 on the day of the procedure. If the patient has a mechanical heart valve, hospital admission should be arranged for heparin therapy when warfarin is stopped.
3. Diabetics on insulin should take half the usual dose on the morning of the procedure. Diabetics on oral medications may take the usual dose.
4. We recommend prophylactic antibiotics only if:
   - The patient has a history of bacterial endocarditis or has a mechanical heart valve
   - The patient is likely to need dilation of a stricture or sclerotherapy of varices and has an abnormal heart valve.

   If prophylactic antibiotics will be required, we should be notified (919-966-2310) and the patient should arrive 90 minutes before the scheduled time.
5. We may elect to schedule selected patients in clinic before scheduling their procedure

PLEASE INFORM YOUR PATIENT

Space and personnel have been assigned to do this procedure. The patient should call us (919-966-2310) **at least 4 working days** before the procedure date if they cannot keep the appointment.

Instructions to prepare for the procedure will be sent to the patient's home. The instructions should be **read as soon as they are received and followed carefully**. If instructions are not received 4 working days before the procedure the patient should call 919-966-2310.



UNC HealthCare GI Procedure Request Form

Please provide the information listed below and fax completed form to **(919) 966-8764**.
If you would like us to do a pre-procedure assessment, call (919) 966-0173 to arrange a clinic visit.

Procedure requested: **Urgent?:** ❑ Yes ❑ No

❑ EGD ❑ Colonoscopy ❑ Flex. Sig. ❑ E. mano ❑ Other:______________

Patient Information: (PLEASE COMPLETE INSURANCE INFORMATION ON NEXT PAGE)

First Name: _________________________________ UNCH #: ____________________

Last Name: _________________________________ Birthdate:_____ / _____ /

Address: _________________________________ SSN#: ______ - ____ - _____

_________________________________ Home phone: (____) ____________

_________________________________ Work phone: (____) ____________

Other phone: (____) ____________

Requesting MD Information:

UNC MD Name:_________________________ UNC MD Code #: __________________

Non-UNC MD Name: _________________________

Address:_________________________ Phone: __________________

_________________________ Fax: __________________

Reason for the Procedure (check one or more):

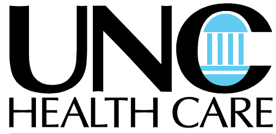
❑ colon screening	❑ diarrhea	❑ abnormal X-ray	❑ PtHx. colon ca or adenoma
❑ guaiac pos. stool	❑ constipation	❑ reflux	❑ FHx colon ca or adenoma
❑ rectal bleeding	❑ ulcerative colitis	❑ Crohn's disease	❑ dyspepsia
❑ anemia	❑ fecal incontinence	❑ weight loss	❑ noncardiac chest pain
❑ nausea/vomiting	❑ upper GI bleeding	❑ dysphagia	❑ other ________________

Pertinent patient conditions (check one or more):

❑ none	❑ on warfarin	❑ diabetes – on insulin	❑ mechanical heart value
❑ CHF	❑ on antiplatelet agent	❑ renal failure	❑ internal defibrillator
❑ COPD	❑ other bleeding tendency	❑ liver failure	❑ other _______________

PROCEDURE SCHEDULED: Date: ____ / ____ / ____ Time: ___________

If this date is not satisfactory, call (919) 966-2310 and ask to speak to
Dr. Ian Grimm or the endoscopy attending on call.



UNC HOSPITALS
GASTROENTEROLOGY AND HEPATOLOGY CLINICS
101 Manning Drive, Chapel Hill, NC 27514

☐ **GI General & Specialty Clinic**
Ph: toll free 877-668-0680
local 919-966-6000
FAX: 919-843-2633

☐ **Biliary & Pancreatic Disorders**
☐ **Esophageal Diseases & Swallowing**
Ph: 919-966-2513 FAX: 919-843-2508

☐ **Hispanic/Capsule Endoscopy**
Ph: 919-843-3183 FAX: 919-966-6842

☐ **Inflammatory Bowel Disease (IBD)**
Ph: 919-966-0140 FAX: 919-843-6899

☐ **Functional Gastrointestinal Disorders (IBS)**
Ph: 919-966-0141 FAX: 919-966-2250

☐ **Liver Disease & Transplantation**
Ph: 919-966-2516 FAX: 919-966-1700

REGISTRATION/INTAKE FORM

Patient Information **UNC MR# (*if known*):**

Last Name	First Name	Middle Name
Soc Sec No Sex:	Birth Date	Race: U.S. Citizen
Street Address		Home Phone #
City	State	Zip

Responsible Party (the person who pays the patient's portion of the bill) LEAVE BLANK IF SELF

Last Name	First Name, MI	Date of Birth SEX: F ☐
Street Address		Home Phone #
City	State	Zip
Employer	Work Phone #	Soc. Sec.#
Relationship to Patient (Check One): ☐Self ☐Spouse ☐Child ☐Parent ☐Other		
Emergency Contact	Relationship to Patient	Contact Phone #

Primary Insurance Policy Holder Information (Subscriber)
COPY OF INSURANCE CARD FRONT AND BACK

Last Name	First Name MI	Date of Birth SEX: F ☐
Employer Name	Work Phone #	Soc. Sec.#
Name of Insurance ☐ HMO ☐PPO ☐ other	Policy #:	Group #:
Effective Dates of Insurance Coverage	Claims Address (on Insurance Card)	
Patient's Relationship to the Policy Holder- (Check One): ☐Self ☐Parent ☐Spouse ☐Child ☐Other		
☐ Employed FT ☐ Not Employed ☐ Retired ☐ Not Used Unknown ☐ Employed PT ☐ Self Employed		

Secondary Insurance Policy Holder Information

Last Name	First Name MI	Date of Birth SEX: F ☐
Employer Name	Work Phone #	Soc. Sec.#
Name of Insurance ☐ HMO ☐PPO ☐ other	Policy # Group #	
Effective Dates of Insurance Coverage	Claims Address (on Insurance Card)	
Patient's Relationship to the Policy Holder- (Check One): ☐Self ☐Parent ☐Spouse ☐Child ☐Other		
☐ Employed FT ☐ Not Employed ☐ Retired ☐ Not Used Unknown ☐ Employed PT ☐ Self Employed		