**UNC Endoscopy Center at Meadowmont** 300 Meadowmont Village Circle, Suite 335 Chapel Hill, NC 27517

Phone: (919) 843-7200, Fax (919) 843-7136

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GI Procedures Order Form MIM # 1224

UNC GI Procedures at UNC Hospitals 101 Manning Drive, Chapel Hill, NC Chapel Hill, NC 27514 Phone: (919) 966-2310, Fax (919) 966-8764 schGlHÒ@unch.unc.edu

First Name:	Please provide the information requested and return via fax. F Patient Information:	For a pre-procedure clinic consultation, call (919) 966-6000 (option 2).
Birth Date:		ast Name:
Medicare phone: Workoffeer phone: Phone: Phone: Phone: Phone: Phone: Phone: Phone: P		
ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary diagnosis and treatment of a patient, rather than for screening purposes.  Procedure(s) Ordered:    EGD	Home phone: Wo	ork/other phone
□ EGD □ Colonoscopy □ Flexible Sigmoldoscopy □ Capsule Endoscopy * □ RERCP * □ Ileoscopy □ Upper EUS * □ Lower EUS * □ Push Enteroscopy * □ Deep Enteroscopy * □ Pouch Exam □ Infra-Red Coagulation of Hemorrhoids ** □ Other □ **Non-routine procedures only performed at UNC Memorial Hospital. Please fax relevant notes, labs, pathology, and imaging if not on webClS. Complex procedures will only be scheduled after review of these records. ** Meadowmont only Indication for the procedure(s): □ Where: □ Where: □ Where: □ Where: □ State patient receiving any of the following medications? □ Insulin □ Warfarin (Coumadin) ( Pradaxa) or other anticoagulants □ Anti-platelet medications (e.g., Pulspirin on physician orders □ Ritonovir (Norvir), Atazanavir (Reyataz)  Significant health issues (e.g., cardiac, pulmonary, neurological): □ Patients with the following conditions must be scheduled at UNC Memorial Hospital: □ Patient cannot give own consent: □ Patient cannot give own consent: □ Patient cannot give own consent: □ Name and phone number of health care POA □ □ Patient does not speak English □ Primary language? □ □ Patient has Internal Defibrillator □ Make and model? □ □ Patient is on chronic narcotics, benzodiazepines, or Suboxone  Anesthesia Services Requested: YES □ NO □ Indication: □ Significant Comorbidity □ Chronic narcotic or sedative use □ Difficult airway, sleep apnea □ Anticipated difficult procedure	ordering tests for which Medicare reimbursement will be sought, physically and the sought, physical research and the sought and the	sicians should order only those individual tests that are necessary for the
□Upper EUS * □Lower EUS * □Push Enteroscopy * □ Deep Enteroscopy * □Pouch Exam □ Infra-Red Coagulation of Hemorrhoids ** □Other □ Non-routine procedures only performed at UNC Memorial Hospital. Please fax relevant notes, labs, pathology, and imaging if not on webCis. Complex procedures will only be scheduled after review of these records. ** Meadowmont only Indication for the procedure(s): □ Where: □ Where: □ Where: □ State patient receiving any of the following medications? □ Insulin □ Warfarin (Coumadin) (Pradaxa) or other anticoagulants □ Anti-platelet medications (e.g., Pulspirin on physician orders □ Ritonovir (Norvir), Atazanavir (Reyataz)  Significant health issues (e.g., cardiac, pulmonary, neurological): □ Patients with the following conditions must be scheduled at UNC Memorial Hospital: □ Patient cannot give own consent: □ Patient can only be transported via stretcher □ Patient does not speak English □ Primary language? □ Primary language? □ Patient has Internal Defibrillator Make and model? □ Patient is on chronic narcotics, benzodiazepines, or Suboxone  Anesthesia Services Requested: YES □ NO □ Indication: □ Significant Comorbidity □ Chronic narcotic or sedative use □ Difficult airway, sleep apnea □ Anticipated difficult procedure	Procedure(s) Ordered:	
Infra-Red Coagulation of Hemorrhoids **	☐ EGD ☐ Colonoscopy ☐ Flexible Sigmoidoscopy	y □Capsule Endoscopy * □ERCP * □ Ileoscopy
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I certify that the diagnosis provided support the tests ordered and are medically necessary.	□ Pauent Request	
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Requesting MD Signature: ID# Date & Time	Requesting MD Signature:	
MD Name (please print) Phone: Fax:	MD Name (please print)	Phone:Fax: