UNC Endoscopy Center at Meadowmont
300 Meadowmont Village Circle, Suite 335
Chapel Hill, NC 27517
Phone: (919) 843-7200, Fax (919) 843-7136
schGIMM@unch.unc.edu

UNC GI Procedures at UNC Hospitals
101 Manning Drive, Chapel Hill, NC
Chapel Hill, NC 27514
Phone: (919) 966-2310, Fax (919) 966-8764
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GI Procedures Order Form MIM # 1224

Please provide the information requested and return via fax. For a pre-procedure clinic consultation, call (919) 966-6000 (option 2).

Patient Information:

First Name: _____ Last Name: _____
UNC # _____ Birth Date: _____
Home phone: _____ Work/other phone _____

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a) (1) of the Medicare Law. When ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening purposes.

Procedure(s) Ordered:

☐ EGD ☐ Colonoscopy ☐Flexible Sigmoidoscopy ☐Capsule Endoscopy * ☐ERCP * ☐ 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 reports if not on webCIS. Complex procedures will only be scheduled after review of these records. ** Meadowmont only

Indication for the procedure(s): _____
For screening colonoscopy: Date of last procedure? _____ Where: _____

Is the patient receiving any of the following medications?

☐Insulin ☐Warfarin (Coumadin) (Pradaxa) or other anticoagulants ☐Anti-platelet medications (e.g., Plavix)

☐Aspirin 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 has a port-a-catheter ☐Patient can only be transported via stretcher
☐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
☐ Patient Request

I certify that the diagnosis provided support the tests ordered and are medically necessary.

Requesting MD Signature: _____ ID# _____ Date & Time _____
MD Name (please print) _____ Phone: _____ Fax: _____

PROCEDURE SCHEDULED: Date: _____ / _____ / _____ Time: _____ Chart Location: Provider Orders