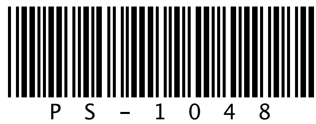
EMORY HEALTHCARE



DTC GI Lab Order Form
FAX orders to: 404.501.5703
Phone: 404.501.5580

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:** _____________