

MRN: _____
Patient Name: _____

(Patient Label)

**GI MOTILITY & CAPSULE ENDOSCOPY
ENDOSCOPIC PROCEDURES REFERRAL FORM**
100 UCLA Medical Plaza, Suite 205, Los Angeles, CA 90095
P (310) 825-7540 F (310) 825-5176

SECTION 1 Patient Information (Consult required for pediatric GI patients – call 310-825-0867)

Name _____
Date of Birth (mm-dd-year) _____ Gender Male Female
UCLA ID (optional) _____ Preferred Phone Number _____
Street Address _____ Apt# _____
City _____ State _____ Zip Code _____
Insurance company _____ ID # _____ PPO HMO (auth #) _____

SECTION 2 Procedure / Consult Request

➤➤➤**Diagnosis** _____ **ICD-10** _____ **Consult request:** Preferred physician (optional): _____

ENDOSCOPIC PROCEDURES

Priority Routine Urgent (10 business days)
Sedation: Monitored Anesthesia Care
Esophageal Manometry with Endoscopic Placement
 EGD w/ impedance esophageal manometry (43235, 91010, 91037)
 EGD w/ impedance esophageal manometry with food (43235, 91010, 91037)
 EGD w/ esophageal manometry (43235, 91010)
 EGD w/ esophageal manometry with food (43235, 91010)

Capsule endoscopy placed via EGD (91110, 43235)
→Does the patient any of the following?
H/o bowel obstruction or intestinal surgery? Yes No
Pacemaker or defibrillator? Yes No
Is the patient pregnant? Yes No

EGD with Wireless Bravo™ pH testing
(Bravos are NOT performed with EGD with esophageal manometry)
 EGD w/ 48-hr Bravo™ pH OFF acid suppression (43235, 91035)
 EGD w/ 48-hr Bravo™ pH ON acid suppression (43235, 91035)
 EGD w/ 96-hr Bravo™ pH (43235, 91035) - 2 days OFF acid suppression, followed by 2 days ON
→For Bravo™: Does the patient exhibit any of the following?
Coagulopathy? Yes No
Esophageal varices, stricture, or ulcer? Yes No
Esophageal or bowel obstruction? Yes No
Pacemaker or implantable defibrillator? Yes No
Allergy to nickel or fake jewelry? Yes No

SECTION 3 Patient History

Height _____ **Weight** _____ **BMI** _____
 MAO Inhibitor use Anticoagulated

Heart Disease:	Respiratory:	Other:
<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
<input type="checkbox"/> CHF	<input type="checkbox"/> COPD	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Angina at rest	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Valvular disease/repair	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> IDDM
<input type="checkbox"/> Dysrhythmia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary hypertension	<input type="checkbox"/> Potential for pregnancy
		<input type="checkbox"/> Morbid obesity
		<input type="checkbox"/> Previous sedation complication

Wire-based intraesophageal pH testing
(Initial esophageal manometry required)
 EGD with 24-hr pH OFF acid suppression (91034)
 EGD with 24-hr pH ON acid suppression (91034)
 EGD with 48-hr pH OFF acid suppression (91034)
 EGD with 48-hr pH ON acid suppression (91034)
 EGD with 24-hr pH-impedance OFF acid suppression (91038)
 EGD with 24-hr pH-impedance ON acid suppression (91038)

SUBMIT THE REFERRAL:

- Fax the following to (310) 825-5176:
- Completed referral form
 - Face sheet/demographics
 - History & physical (including allergy and medication list)
 - Last progress note/rationale for selected procedures
 - Diagnostic reports (cardiac reports, labs)

If any of the requested information is missing or incomplete, it may delay scheduling.

SECTION 4 Referred by

Physician (print name) _____ Specialty _____
Referring physician signature: _____ Date: _____ Time: _____
Phone Number: _____ Fax Number _____ Clinic contact person: _____