UCLA Health

PATIENT REFERRAL FORM
GASTROINTESTINAL FUNCTION TESTING

MRN:
Patient Name:

(Patient Label)

Phone – (310) 825–7540 | Fax – (310) 825-5176

Referring MD ____ Specialty ____________________
Street ____ Suite # _____________________
City _________________________________ State ________________ Zip Code ___________
Phone Number ___________________________ Fax Number ___________________________
Email address ____________________________

Patient Information (Consult required for pediatric GI patients – call (310) 825-0867)
Last Name _________________________ First Name ________________________ MI _______
Date of Birth (mm-dd-year) _________________________ Gender ☐ Male ☐ Female
UCLA ID or EPIC ID (optional) _______________________________
Street Address ____ Apt # _______
City _________________________________ State ________________ Zip Code ___________
Home Phone ________________ Work Phone ________________ Cell Phone ________________

Diagnosis ____ ICD–10_______________________
Allergies ____

Esophageal function testing

☐ Hi–resolution esophageal manometry (91010)
- ☐ W/ impedance (91010, 91037) ☐ W/O impedance
- ☐ With food challenge
- ☐ Place via endoscopy (43235) - **complete pg. 2**

☐ Bravo™ wireless intraesophageal pH w/ EGD *(91035,43235)* - **complete pg. 2**
- ☐ OFF acid suppression ☐ ON acid suppression
- ☐ 48-hr ☐ 96-hr

(Note: 96-hr Bravo is performed 2 days off acid suppression and then 2 days on)

☐ Wire-based intraesophageal pH* *(91034)*
- ☐ OFF acid suppression ☐ ON acid suppression
- ☐ 24-hr ☐ 48-hr

☐ Wire-based intraesophageal impedance pH* *(91038)*
- ☐ OFF acid suppression ☐ ON acid suppression
- ☐ 24-hr ☐ 48-hr

*Esophageal manometry is required to determine LES location for catheter-based pH test. If previous manometry available, please send a copy of the report.

Anorectal function testing

☐ Anorectal biofeedback 3 sessions (90912, 90913)
☐ Hi–resolution anorectal manometry (91122,91120)

Gastrointestinal transit and motility

☐ SmartPill™ (gastric emptying, small bowel and colonic transit) (91112)

Hormone stimulation

☐ Secretin stimulation (Gastrinoma) (82938)
☐ Sham feeding (Vagotomy) (83519)

☐ Capsule endoscopy (91110)

- ☐ Place via endoscopy (complete page 2) (43235)

☐ Consult request

Physician preferred:
(optional) ________________________________

Attach medication list and fax form to (310) 208-3788 or call (310) 208-5400

Clinic contact person: ___________________________ Phone: ____________________________
Referring physician signature: __________________________________Date:__________________
Insurance company:____________________________ ☐ HMO ☐ PPO Group #:_______________

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PAGE 2 - REQUIRED IF ORDERING BRAVO OR IF UPPER ENDOSCOPY IS BEING USED TO PLACE ESOPHAGEAL HI-RESOLUTION IMPEDANCE MANOMETRY OR CAPSULE ENDOSCOPY

Name of Patient____

DOB____

Please mark YES or NO to the questions below.

☐ Is the patient currently taking any chronic narcotics?
 ☐ Yes ☐ No

☐ Is the patient currently taking any NSAIDs?
 ☐ Yes ☐ No

☐ Does the patient currently have cardiac/pulmonary disease?
 ☐ Yes ☐ No

☐ Is the patient taking any anti-coagulants?
 ☐ Yes ☐ No

☐ Is the patient currently taking any mood stabilizers?
 ☐ Yes ☐ No

☐ Is the patient's BMI greater than 50?
 ☐ Yes ☐ No

Please submit all required medical records with this procedure request form. If any of the requested information on this form is missing or incomplete, it might delay the scheduling of your patient's procedure.

Clinic contact person: ___________________________ Phone: ___________________________

Referring physician signature: ______________________ Date:____________________________