UCLA Health

SMALL BOWEL ENDOSCOPY PROGRAM
PROCEDURES REFERRAL FORM

1223 16th Street, Suite 3100, Santa Monica, CA 90404
P (310) 582-6240 F (424) 259-7789

MRN:

Patient Name:

SECTION 1 Patient Information

Name (Last, Middle, First) _____

Date of Birth (mm-dd-year) _____ | Gender: ☐ Male ☐ Female | Preferred language _____

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 _____

Priority ☐ Routine ☐ Urgent (10 business days)

☐ **Consult Request:** Dr. Otis Stephen

PROCEDURES

Sedation: ☒ Monitored Anesthesia Care (other sedation needs require consult)

Double Balloon Enteroscopy
- ☐ Upper (44799, 00731)
- ☐ Lower (45399, 00811)
- ☐ Upper & Lower (44799, 45399, 00811)

Push Enteroscopy
- ☐ Upper (44360, 44361, 44376, 44377, 00731)

☐ **Colonoscopy (45378, 45380, 45385, 00811)**
***Include prior colonoscopy report**

Capsule Endoscopy
- ☐ **Placed in clinic** (91110)
- ☐ **Placed via EGD** (91110, 43235, 00811)

→ **Does the patient have any of the following?**

H/o bowel obstruction or intestinal surgery? Yes ☐ No ☐

Pacemaker or defibrillator? Yes ☐ No ☐

Is the patient pregnant? Yes ☐ No ☐

SECTION 3 Patient History

Height _____ **Weight** _____ **BMI** _____

1. Is the patient taking anticoagulants or antiplatelet besides chronic NSAIDs, or low-dose aspirin?
   Yes ☐ No ☐
2. Is the patient taking GLP-1 agonist medication?
   Yes ☐ No ☐
3. Does the patient have a latex allergy? Yes ☐ No ☐

4. Heart Disease
- ☐ N/A
- ☐ CHF
- ☐ Angina at rest
- ☐ Valvular disease/repair
- ☐ Dysrhythmia
- ☐ Hypertension

5. Respiratory
- ☐ N/A
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Pulmonary hypertension

6. Other
- ☐ N/A
- ☐ Ehlers-Danlos Syndrome
- ☐ Renal disease
- ☐ Liver disease
- ☐ IDDM
- ☐ Seizure disorder
- ☐ Potential for pregnancy
- ☐ Morbid obesity
- ☐ Previous sedation complication

7. Does the patient have an indication not listed above that calls for further review by GI or anesthesia?
   Yes ☐ No ☐

SECTION 4 Referred by

Fax the following to (424) 259-7789: If any of the requested information is missing or incomplete, it may delay scheduling. Include 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, prior endoscopic reports)

Physician Name _____ Specialty _____

Referring Physician Signature _____ Date _____ Time _____

Phone Number _____ Fax Number _____ Clinic Contact Person _____