UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT REFERRAL FORM
GASTROINTESTINAL FUNCTION TESTING

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_____
Medications _____

Esophageal Function Testing

☐ Hi–resolution impedance manometry *(91010, 91037)*
  ☐ Place via endoscopy (complete page 2) (43235)
☐ Wireless 48–hour intraesophageal pH (Bravo) *(91035,43235)*
  Endoscopy required with this procedure (complete page 2)
  ☐ On ☐ Off acid suppression
☐ Wireless 96–hour intraesophageal pH (Bravo)
  Endoscopy required with this procedure (complete page 2) *(91035,43235)*
  ☐ 2 days off, 2 days on acid suppression
  ☐ 4 days off acid suppression
  ☐ 4 days on acid suppression

☐ 24–hour single channel intraesophageal pH* *(91038)*
  ☐ On ☐ Off acid suppression
☐ 24–hour dual channel intraesophageal pH* *(91034)*
  ☐ On ☐ Off acid suppression

☐ 24–hour intraesophageal impedance pH* *(91038)*
  ☐ On ☐ Off acid suppression

Anorectal Function Testing

☐ 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
☐ Fax form to (310) 208-3788 or call (310) 208-5400
Physician preferred:
(optional) _____

*Need to order esophageal manometry to determine LES location for catheter-based pH test, if no prior esophageal manometry done.

Clinic contact person: _____ Phone: _____
Referring physician signature: _____
Insurance company:_____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_____

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: _____