RWJ UNIVERSITY HOSPITAL SOMERSET

GI SCHEDULING FAX: 908-685-2431

PATIENT INFORMATION: (REQUIRED)

Last Name: ______________________ First Name: ______________________

DOB: ______________________ SSN: ______________________

Gender: Male Female Allergies: ______________________

Home Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________ Cell: ______________ Work: ______________

Medical Devices, if applicable: Pacer Defibrillator

Isolation Precautions, if applicable: MRSA C-Diff VRE ESBL

PROCEDURE INFORMATION: (REQUIRED)

Date Requested: ______________________ Time Requested: ______________________ AM PM

Physician Name: ______________________ Patient Type: Same Day Inpatient

Procedure(s): ______________________

Antibiotics Pre-Procedure: Yes No

Written Antibiotics ordered: Yes No

Botox: Yes No (fax order to Pharmacy)

Blood Work ordered: Yes No

Specific Scope Request: Yes No

Kinevac: Yes No

INSURANCE INFORMATION: (REQUIRED)

Primary Insurance: ______________________ Pre Cert/Referral: ______________________

Group #: ______________ Policy #: ______________ CPT Code #: ______________

Address & Phone # of Insurance Company: ______________________

Name of Insured if other than self: ______________________ DOB: ______________

SSN: ______________________

Secondary Insurance: ______________________ Pre Cert/Referral: ______________________

Group #: ______________________ Policy #: ______________________

Name of Insured if other than self: ______________________ DOB: ______________

SSN: ______________________

Workers Comp/MVA Insurance:

Claim#: ______________________ Date of Injury: ______________________

Adjuster's Name & Phone #: ______________________

SCHEDULING DEPT USE ONLY: **Completed By:** ______________________

Patient Scheduling Complete: ☐ **Yes** ☐ **No** **Comments:** ______________________