UCLA Health

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

EGD with Wireless Bravo™ pH Testing
(Bravos are NOT performed with EGD with esophageal manometry)

☐ EGD w/ 96-hr Bravo™ pH OFF acid suppression all 4 days (43235, 91035)

→ 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

Esophageal Manometry with Endoscopic Placement

☐ EGD w/ impedance esophageal manometry (43235, 91010, 91037)

Wire-based Intraesophageal pH Testing
(Initial esophageal manometry required)

☐ EGD with 24-hr pH OFF acid suppression (91034)
☐ EGD with 48-hr pH OFF acid suppression (91034)
☐ EGD with 24-hr pH-impedance OFF acid suppression (91038)
☐ EGD with 24-hr pH-impedance ON acid suppression (91038)

☐ **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

SECTION 3 Patient History

Height **Weight** **BMI**

☐ MAO Inhibitor use ☐ Anticoagulated

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

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: