EMORY
HEALTHCARE

(Patient Label)

ENDO SURGERY - DOWNTIME SCHEDULING REQUEST

MANDATORY – ALL highlighted areas must be answered or request will not be scheduled and sent back.

Please fax this form to the appropriate location:
ASC: 478-329-3454
WR: 478-975-5229
WR Endo: 478-322-4886
WR Outpatient: 478-975-6908
Perry OR: 478-218-1748
Pain: 478-329-3350

Patient Information (Name must match that on their license/ passport)

Patient Last Name:		Patient First Name:	Middle:
DOB:		Gender:	
Home Address:			
City:	State:	Zip:	
Home Phone:	Cell:	Work:	

General Information

Date of Service:	Time:	Outpatient ☐	Inpatient ☐	Surgical Admit ☐
Surgeon:		Assisting Surgeon (same specialty as surgeon):		
Additional Surgeon (Different Specialty than others):		Additional Surgeon (Different Specialty than others):		

Procedure Information

ICD 10 Codes:

CPT CODE (PRIMARY, SECONDARY, ETC.)	**CPT/Procedure Description**	**Laterality:**
		Left Right Bil N/A
		Left Right Bil N/A
		Left Right Bil N/A
		Left Right Bil N/A
Expected Surgery Length:		Fluoro / C-Arm Needed: Yes No
Comments & Instructions / Request for Instruments / Equipment:		

What Are the Procedure Interventions? At Least One Procedure Should be Circled to Schedule the Case.

Colonoscopy Interventions

Biopsy/Brushing/Washing	Decompression	Diagnostic	Dilation
Endoscopic Mucosal Resection (EMR)	Fecal Microbiota Transplant	Foreign Body Removal	Hemorrhage Control
Hemorrhoid Banding	Polyp/Tumor Ablation	Polyp/Tumor Removal	Stent Placement

Tattoo/Submucosal Injection	Screening Colonoscopy	Rectal Dilation
Other:		

EGD Interventions

Biopsy/Cytology	Botox Injection	BRAVO	Diagnostic
Dilation/ Balloon/ Savory/ Guided	Endoscopic Mucosal Resection (EMR)	Esophageal Varices Ligation	Foreign Body Removal
Gastrostomy Tube Insert/ Placement	Gastrostomy Tube Change/ Reposition/ Removal	Hemorrhage Control	Polyp/ Tumor/ Tissue Ablation
Polypectomy/ Tumor Removal	Sclerotherapy	Stent Placement	Tube Placement
Tattoo/ Submucosal Injection		Varices Ligation	
Other:			

ERCP Interventions

Balloon Cholangiogram	Balloon Dilation	Biliary/ Pancreatic Duct Stone Removal	Biopsy/Cytology
Foreign Body Removal	Lithotripsy	Polyp/ Tumor Ablation	Sphincterotomy/ Papillotomy

Spyglass Visualization	Stent Insertion	Stent Removal/ Exchange
Other:		

Is a Hospital Bed Required? (Circle Below)

ICU Bed Required	Non-ICU Bed Required	No Bed Required

Effect on Short-Term Delay on Outcome? (Circle one)

Minimum Risk to Patient	Moderate Risk to Patient	High Risk to Patient

In Person Pre-Admission Testing Needed? (If so, then Guidelines can be Requested Through Schedulers.)

Desired Date:	Desired Time:

Billing Type:

Fully Cosmetic ☐	Partially Cosmetic ☐	Other Billing (See below) ☐
Other Billing Comments:		

Physician's Signature:	**Date:**