Wayne Memorial Hospital
Honesdale PA 18431
P: 570-253-8136
F: 570-251-6508

2022 CAMP REGISTRATION

(This Is A 2 Part Form - Both Pages Required For Outpatient Testing Only)

* C A M P 0 1 *

PATIENT DEMOGRAPHIC INFORMATION

Patient Type (Select One): ☐ Camper ☐ Camp Staff - ***NOT*** Work Related ☐ Camp Staff – Work Related

Patient Name (Last, First):	**Patient Date of Birth:**
Sex ☐ Male ☐ Female ☐ Unknown	**Gender Identity:**
Home Address (Street, City, State & Zip):	**Primary Care Provider:**
Home Phone:	**Other Phone**:
Email (used to enroll in the myWMH Patient Portal):	**Patient Social Security Number**:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Life Partner ☐ Unknown ☐ Other

Race: ☐ African American ☐ Asian ☐ Native American ☐Other Pacific Islander ☐ White
☐ Declined to Answer ☐ Other _____

CONTACT INFORMATION

Next of Kin/Notify In Emergency (Last, First):	**Relationship To Patient:**
Home Address (Street, City, State & Zip): ☐ **Same As Patient**	
Home Phone:	**Other Phone**:

GUARANTOR INFORMATION

(Person financially responsibility to pay the patient's bill after insurance)

Guarantor Name:	**Relationship To Patient:**
Guarantor Address (Street, City, State & Zip): ☐ **Same As Patient**	
Home Phone:	**Other Phone:**

INSURANCE INFORMATION

Insurance Company Name:	**Insurance Company Phone #:**
Insurance Company Address	
Subscriber Name:	**Subscriber ID:**

CAMP INFORMATION

Camp Name:	**Infirmary Phone #:**	**Infirmary Fax #:**
Camp Address:		

This will certify that the camp has obtained and has on file, or has provided Wayne Memorial Hospital, a consent to obtain medical or surgical treatment and hospital care for the above named individual, and authorizes camp officials to consent to treatment and to receive/release patient health information in accordance with HIPAA rules and regulations.

Authorized Camp Personnel Name (Print) **Sign:**

_____ _____

IS THIS AN EMERGENCY ROOM VISIT?

☐ **YES Reason for Visit: _____ (Stop here, do not fill out page 2)**

☐ **NO (Proceed to page 2 and complete outpatient testing order request)**

AFFIX PATIENT LABEL

Wayne Memorial Hospital
Honesdale PA 18431
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2022 CAMP OUTPATIENT ORDERS

(This Is A 2 Part Form - Both Pages Required For Outpatient Testing Only)

* C A M P 0 1 *

PATIENT INFORMATION

Patient Type (Select One): ☐ Camper ☐ Camp Staff - ***NOT*** Work Related ☐ Camp Staff – Work Related

Patient Name (Last, First): | **Patient Date of Birth:**

Sex ☐ Male ☐ Female ☐ Unknown | **Gender Identity:**

LABORATORY STUDIES

☐ STAT (4hr TAT) ☐ Routine (24 hr TAT) | **Diagnosis (Required):**

- ☐ Comp. Metabolic Profile
- ☐ Basic Metabolic Profile
- ☐ Renal Function Profile
- ☐ Electrolyte Profile
- ☐ CBC With Differential
- ☐ CBC Without Differential
- ☐ Other Tests: _____ _____

- ☐ Urinalysis
- ☐ Rapid Strep A
- ☐ Lyme IgG/IgM
- ☐ Tick Born Disease Panel
- ☐ CT\NG PCR
- ☐ GI Panel
- _____

- ☐ Culture, Throat
- ☐ Culture, Urine Void
- ☐ Culture, Other (Specify Source_____)
- ☐ Covid 19
- ☐ Respiratory Panel including Covid 19

IMAGING STUDIES

Diagnosis (Required):

DIAGNOSTIC RADIOLOGY

- ☐ Skull
- ☐ Orbits
- ☐ Nasal Bones
- ☐ Mandible
- ☐ Facial Bones
- ☐ TMJ
- ☐ Sternum
- ☐ KUB
- ☐ Obstruction Series
- ☐ Pelvis
- ☐ Pelvis with Frog
- ☐ Bilateral Hips w/ AP Pelvis
- ☐ SI Joints
- ☐ Sacrum/Coccyx
- ☐ Chest AP/LAT
- ☐ Chest 1 View
- ☐ Cervical Spine ☐ AP/LAT Only
- ☐ Thoracic Spine ☐ AP/LAT Only
- ☐ Lumbar Spine ☐ AP/LAT Only

PLEASE CHOOSE BOTH BODY PART AND LATERALITY

☐ Clavicle	☐ L ☐ R	☐ Bilateral	☐ Hand	☐ L ☐ R	☐ Bilateral
☐ Scapula	☐ L ☐ R	☐ Bilateral	☐ Finger	☐ L ☐ R	☐ Bilateral
☐ Shoulder	☐ L ☐ R	☐ Bilateral	☐ Hip	☐ L ☐ R	☐ Bilateral
☐ Ribs	☐ L ☐ R	☐ Bilateral	☐ Femur	☐ L ☐ R	☐ Bilateral
☐ Ribs w/1 view Chest	☐ L ☐ R	☐ Bilateral	☐ Knee	☐ L ☐ R	☐ Bilateral
☐ Humerus	☐ L ☐ R	☐ Bilateral	☐ Tibia/Fibula	☐ L ☐ R	☐ Bilateral
☐ Elbow	☐ L ☐ R	☐ Bilateral	☐ Ankle	☐ L ☐ R	☐ Bilateral
☐ Forearm	☐ L ☐ R	☐ Bilateral	☐ Foot	☐ L ☐ R	☐ Bilateral
☐ Wrist	☐ L ☐ R	☐ Bilateral	☐ Toe	☐ L ☐ R	☐ Bilateral

Other Studies: _____

ADVANCED IMAGING

MODALITY	BODY PART (write legibly)	CONTRAST
☐ CT		☐ With ☐ Without ☐ With Out & With
☐ MRI		☐ With ☐ Without ☐ With Out & With
☐ US		Not applicable

Provider Name: **Provider Signature:** **Date:**

License#: **NPI:**

AFFIX PATIENT LABEL