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

2026 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) Not Camp Address:	**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 Date of Birth:**
Subscriber ID & Group #:	**Subscriber Relationship to Patient:**

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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2026 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**
- ☐ **Covid 19, Flu-A, Flu-B, RSV PCR**
- ☐ ***Respiratory Panel including Covid 19*****

***These tests are not covered by insurance. Guarantor will be responsible for payment in full.*

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