



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

2026 CAMP REGISTRATION

F: 570-251-6508 (This Is A 2 Part Form - Both Pages Required For Outpatient Testing Only)



PATIENT DEMOGRAPHIC INFORMATION		
Patient Type (Select One): <input type="checkbox"/> Camper <input type="checkbox"/> Camp Staff - NOT Work Related <input type="checkbox"/> Camp Staff – Work Related		
Patient Name (Last, First):		Patient Date of Birth:
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Unknown <input type="checkbox"/> Other		
Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Other _____		
CONTACT INFORMATION		
Next of Kin/Notify In Emergency (Last, First):		Relationship To Patient:
Home Address (Street, City, State & Zip): <input type="checkbox"/> 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): <input type="checkbox"/> 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:		Infirmery Phone #:
Infirmery 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?		
<input type="checkbox"/> YES Reason for Visit: _____ (Stop here, do not fill out page 2)		
<input type="checkbox"/> NO (Proceed to page 2 and complete outpatient testing order request)		



2026 CAMP OUTPATIENT ORDERS

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



PATIENT INFORMATION			
Patient Type (Select One): <input type="checkbox"/> Camper <input type="checkbox"/> Camp Staff - NOT Work Related <input type="checkbox"/> Camp Staff – Work Related			
Patient Name (Last, First):			Patient Date of Birth:
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Gender Identity:	
LABORATORY STUDIES			
<input type="checkbox"/> STAT (4hr TAT) <input type="checkbox"/> Routine (24 hr TAT)		Diagnosis (Required):	
<input type="checkbox"/> Comp. Metabolic Profile	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Culture, Throat	
<input type="checkbox"/> Basic Metabolic Profile	<input type="checkbox"/> Rapid Strep A	<input type="checkbox"/> Culture, Urine Void	
<input type="checkbox"/> Renal Function Profile	<input type="checkbox"/> Lyme IgG/IgM	<input type="checkbox"/> Culture, Other	
<input type="checkbox"/> Electrolyte Profile	<input type="checkbox"/> Tick Born Disease Panel	(Specify Source _____)	
<input type="checkbox"/> CBC With Differential	<input type="checkbox"/> CT\NG PCR	<input type="checkbox"/> Covid 19	
<input type="checkbox"/> CBC Without Differential	<input type="checkbox"/> GI Panel**	<input type="checkbox"/> Covid 19, Flu-A, Flu-B, RSV PCR	
<input type="checkbox"/> Other Tests: _____		<input type="checkbox"/> 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			
<input type="checkbox"/> Skull	<input type="checkbox"/> KUB	<input type="checkbox"/> Chest AP/LAT	<input type="checkbox"/> Chest 1 View
<input type="checkbox"/> Orbits	<input type="checkbox"/> Obstruction Series		
<input type="checkbox"/> Nasal Bones	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> AP/LAT Only
<input type="checkbox"/> Mandible	<input type="checkbox"/> Pelvis with Frog	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> AP/LAT Only
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Bilateral Hips w/ AP Pelvis	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> AP/LAT Only
<input type="checkbox"/> TMJ	<input type="checkbox"/> SI Joints		
<input type="checkbox"/> Sternum	<input type="checkbox"/> Sacrum/Coccyx		
PLEASE CHOOSE BOTH BODY PART AND LATERALITY			
<input type="checkbox"/> Clavicle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Hand	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Scapula	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Finger	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Hip	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Ribs	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Femur	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Ribs w/1 view Chest	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Knee	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Humerus	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Tibia/Fibula	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Elbow	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Ankle	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Forearm	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Foot	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
<input type="checkbox"/> Wrist	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral	<input type="checkbox"/> Toe	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Bilateral
Other Studies: _____			
ADVANCED IMAGING			
MODALITY	BODY PART (write legibly)	CONTRAST	
<input type="checkbox"/> CT		<input type="checkbox"/> With	<input type="checkbox"/> Without <input type="checkbox"/> With Out & With
<input type="checkbox"/> MRI		<input type="checkbox"/> With	<input type="checkbox"/> Without <input type="checkbox"/> With Out & With
<input type="checkbox"/> US		Not applicable	
Provider Name:		Provider Signature:	
Date:		Date:	
License#:		NPI:	

AFFIX PATIENT LABEL