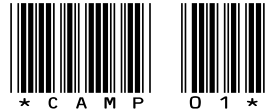
Wayne Memorial Hospital
Honesdale PA 18431
P: 570-253-8136
F: 570-251-6508

2024 CAMP REGISTRATION

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



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 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, <u>do not</u> 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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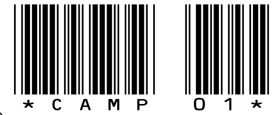
2024 CAMP OUTPATIENT ORDERS

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



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**	☐ **Urinalysis**	☐ **Culture, Throat**
☐ **Basic Metabolic Profile**	☐ **Rapid Strep A**	☐ **Culture, Urine Void**
☐ **Renal Function Profile**	☐ **Lyme IgG/IgM**	☐ **Culture, Other**
☐ **Electrolyte Profile**	☐ **Tick Born Disease Panel**	**(Specify Source___________________________)**
☐ **CBC With Differential**	☐ **CT\NG PCR**	☐ **Covid 19**
☐ **CBC Without Differential**	☐ ***GI Panel****	☐ **Covid 19, Flu-A, Flu-B, RSV PCR**
☐ **Other Tests:** ________________	____________________	☐ ***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**	☐ **KUB**	☐**Chest AP/LAT**	☐ **Chest 1 View**
☐ **Orbits**	☐ **Obstruction Series**		
☐ **Nasal Bones**	☐ **Pelvis**		
☐ **Mandible**	☐ **Pelvis with Frog**	☐ **Cervical Spine**	☐**AP/LAT Only**
☐ **Facial Bones**	☐ **Bilateral Hips w/ AP Pelvis**	☐ **Thoracic Spine**	☐**AP/LAT Only**
☐ **TMJ**	☐ **SI Joints**	☐ **Lumbar Spine**	☐**AP/LAT Only**
☐ **Sternum**	☐ **Sacrum/Coccyx**		

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