

Date of Referral: ____/____/____

Referring Physician: _____

Contact Person: _____

Phone #: _____

Fax #: _____

Address: _____

Please attach the most recent history and physical**PATIENT INFORMATION**

Name: (Last) _____ (First) _____ (MI) _____

DOB: ____/____/____

Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____

Subscriber's Name: _____

ADDITIONAL HISTORY

Procedure requested: ☐ Anorectal Manometry ☐ Colonoscopy ☐ Endoscopic US ☐ ERCP
☐ Esophageal Manometry ☐ Flex Sigmoidoscopy ☐ Upper Endoscopy and Colonoscopy
☐ pH 24-hour Intranasal Study ☐ Upper Endoscopy (without anticipated intervention)
☐ Upper Endoscopy (with anticipated intervention) ☐ Upper Endoscopy with Bravo Placement
☐ Other Indications _____

Any history of anesthesia/sedation intolerance? ☐ Yes ☐ NoIs there a family history of GI cancer? ☐ Yes ☐ No Where? _____Anticoagulation/antiplatelet therapy: ☐ Yes ☐ No Why? _____If yes, please list medication: ☐ Coumadin ☐ Aspirin ☐ Plavix ☐ Other: _____If yes, can therapy be stopped 5-7 days prior to procedure?: ☐ Yes ☐ NoDoes patient have: Cardiac disease (i.e. recent MI, CHF, unstable angina)? ☐ Yes ☐ NoProsthetic device (i.e. heart valve) requiring antibiotic prophylaxis? ☐ Yes ☐ NoCardiac pacemaker or defibrillator? ☐ Yes ☐ NoPulmonary disease (i.e. COPD, sleep apnea, O2 therapy)? ☐ Yes ☐ NoDiabetes mellitus? ☐ Yes ☐ NoEnd-stage renal disease/on dialysis? ☐ Yes ☐ NoHistory of stroke, seizures, cognitive impairment? ☐ Yes ☐ NoRecent stents? ☐ Yes ☐ NoMalignant Hyperthermia? ☐ Yes ☐ NoCan patient give consent? ☐ Yes ☐ No