

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 ☐ No

 Is 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 ☐ No

 Does patient have: Cardiac disease (i.e. recent MI, CHF, unstable angina)? ☐ Yes ☐ No

 Prosthetic device (i.e. heart valve) requiring antibiotic prophylaxis? ☐ Yes ☐ No

 Cardiac pacemaker or defibrillator? ☐ Yes ☐ No

 Pulmonary disease (i.e. COPD, sleep apnea, O2 therapy)? ☐ Yes ☐ No

 Diabetes mellitus? ☐ Yes ☐ No

 End-stage renal disease/on dialysis? ☐ Yes ☐ No

 History of stroke, seizures, cognitive impairment? ☐ Yes ☐ No

 Recent stents? ☐ Yes ☐ No

 Malignant Hyperthermia? ☐ Yes ☐ No

 Can patient give consent? ☐ Yes ☐ No