WVU Medicine

Gastroenterology/Hepatology – Procedure

PHONE: **304-598-4855** FAX: **304-598-6831** **PO Box 9161, Morgantown, WV 26506-8012**

Date of Referral: ______/______/______

Please attach the most recent history and physical

Referring Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Address: ____

Reason for Referral: ____

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: ☐ **EGD** ☐ **Colonoscopy** ☐ **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**

Can patient give consent? ☐ **Yes** ☐ **No**