WVUMedicine

Gastroenterology/Hepatology – Procedure

PHONE: **304-598-4855** FAX: **304-293-2135** **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**