Procedure Screening Form

Patient Name: _____ **MRN:**_____ **DOB**: _____ **Age**: _____

Phone: _____ (***if <18 or >80 must be reviewed by GI physician***)

Insurance: _____ **Procedure**: ☐ EGD ☐ Colon ☐ Flex Sig ☐ Other _____

Preferred Physician: _____

Referral Type: ☐ Self-Referral ☐ Recall letter ☐ PCP office ☐ GI office

Last Endoscopy *(Date, Physician, Location):* _____

Indication/Reason: _____

Screening <45 yrs. (Must be reviewed by GI physician)

Referring physician/PCP: _____ Pharmacy: _____

SCREENING PROFILE

Weight: _____ Height _____ BMI _____ ***(Weight >400 lbs or BMI >50 must be scheduled at hospital)***

For BMI > 45 Prior to scheduling pt. health history needs reviewed and signed by GI physician

Allergies: ☐ NKDA ☐ Other _____

Do you use any assistive devices for getting around?_____

If so, can you bear weight and get in and out of bed on your own without assistance? ☐ **Yes** ☐ **No**

Yes	**No**	
☐	☐	Are you diabetic? ☐ Type I ☐ Type II
		Do you take? ☐ Insulin? ☐ Oral medications? ☐ Other injectables? Please list medication(s):_____
☐	☐	Do you take any weight loss medications? Choose one _____
☐	☐	Do you use cannabis or take edibles? # of times per week _____
☐	☐	Do you drink alcohol? # of drinks per week_____
☐	☐	Medication for sleep/pain/anxiety? _____

Needs GI physician review if patient answers "yes" to any of the following questions:

Yes	**No**	
☐	☐	Have you been treated for ☐ C-Diff ☐ MRSA ☐ VRE within the last month? (If yes, send to physician for review)
☐	☐	Have you ever been told that during surgery it was difficult to place a breathing tube? _____
☐	☐	Do you take any blood thinning medications? *(Baby ASA/NSAIDS ok)*
		Medication name: _____ Prescribing Dr.: _____
☐	☐	Do you have congestive heart failure? Cardiologist: _____
☐	☐	Have you had any active heart problems in the past 6 months? _____
☐	☐	Have you ever had open heart surgery? _____
☐	☐	Any electronic implanted devices? _____ *(internal defib- schedule at hospital)*
☐	☐	Do you use oxygen at home or have severe lung problems?
		Describe: _____ Pulmonologist: _____
☐	☐	Have you had any major surgeries in the last 6 months? ***(Including joint replacements or heart procedures)***
		List: _____
☐	☐	Are you on dialysis? Dialysis schedule: _____
☐	☐	Do you have Chronic Kidney Disease?
☐	☐	Are you pregnant? Due date: _____ How many weeks gestation are you currently? _____

Notes:_____

_____

_____

Screening Profile completed by: _____ Date: _____

Date sent to GI physician for approval: _____ By: _____

Physician reviewed patient's health record. OK to schedule at ASC by: _____ ☐ **Schedule at hospital**

Physician Signature

Scheduled By: _____ Date: _____ Endoscopist: _____ Date scheduled: _____

Called to Schedule: _____ _____ _____