Pezzone Gastroenterology Associates

DrPezzone.com

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Attached, please find our "Endoscopy Service Form-Patient Information Sheet" for you to complete with your patient's personal information and medical history. Completion of this document allows Pezzone Gastroenterology Associates to be certain that all appropriate precautions are taken with your patient's preparation and procedure instructions. As soon as this form is returned, our appointment staff will call your patient and make arrangements to schedule the examination.

Fax to Pezzone Gastroenterology Associates: 724-503-4429

ENDOSCOPY SERVICE FORM-PATIENT INFORMATION SHEET

Acceptance of your patient for a procedural service does not constitute the assumption of care and/or a consultative service for your patient. For consultations or the transfer of care for your patient, please refer your patient to our office.

1. Referring Physician:_____ 2. Phone #:_____ 3. Fax #:_____

4. Physician Address:_____

5. Patient Name:_____ 6. Patient Phone #:_____

7. Patient Address:_____

8. Patient SSN:_____ 9. Patient Birth date:_____

10. Patient Insurance:_____ Policy #:_____ ID#:_____

Referral Required: YES NO

11. Indication for Procedure: (please circle)

Colonoscopy

a) Abnormal GI x-ray
b) Unexplained gastrointestinal bleeding
c) Iron deficiency anemia
d) Colon cancer screening, high risk
e) Colon cancer screening, low risk
f) Chronic inflammatory bowel disease
g) Chronic unexplained diarrhea
h) Personal history of intestinal cancer
i) Personal history of colon polyp(s)
j) Diverticulosis of colon
k) Heme positive stool
l) Change in bowel habits
m) Personal history of malignant neoplasm of: GI tract, liver, lung and/or bronchus, breast, cervix, uterus and/or ovary, kidney, bone, brain
n) Diarrhea-presumed infectious
o) Tuberculous peritonitis or tuberculosis of intestines or adjacent glands
p) Streptococcus group D infection (enterococcus)-Non-GI
q) Bacterial endocarditis
r) Intestinal angina
s) Ileus
t) Volvulus
u) Intestinal Obstruction
v) Diverticula of colon
w) Post-op functional disorders
x) Megacolon
y) Functional disorders of the intestines
z) Blood in stool
aa) Congenital anomalies of digestive system
bb) Hamartomas of intestine (Peutz-Jeghers Syndrome, Von Hippel-Lindau Disease)
cc) Foreign body in intestine and/or colon

Endoscopy

a) Abdominal pain
b) Nausea
c) Hematemesis
d) Iron deficiency anemia
e) Anorexia
f) Dysphagia
g) Unexplained weight loss
h) Recurrent emesis
i) Abnormal GI x-ray
j) Malnutrition
k) Persistent emesis
l) Gastroparesis
m) Gastrostomy-complication
n) Hiatal hernia
o) Liver cirrhosis
p) Crohn's disease
q) Portal hypertension
r) Malabsorption
s) Gastrointestinal hemorrhage
t) Aortic anomalies
u) Hoarseness
v) Heartburn
w) Abdominal pain-upper abdomen and/or periumbilicus
x) X-ray abnormalities of the GI tract
y) Foreign body
z) Burn of GI tract
aa) Complications of internal prosthetic device
bb) Personal history of GI malignancy
cc) Long-term anticoagulant use, antibiotic use, NSAID use

12. Medical diagnoses:

a) Does the patient have cirrhosis or portal hypertension?	YES	NO
b) Does the patient have severe or unstable cardiopulmonary disease requiring an anesthesiologist?	YES	NO
c) Does the patient have any bleeding disorder?	YES	NO
d) Does the patient have kidney insufficiency or failure?	YES	NO
e) Does the patient have a history of heavy narcotic use (prescribed or illicit)	YES	NO

13. Is the patient currently on (please circle all that are appropriate):

NSAIDS	Coumadin*
Insulin	Heparin-like med (Lovenox)*
Oral Hypoglycemics	Aspirin*
MAOIs	Platelet function inhibitor*

***May we discontinue the anti-coagulant medication for 96 hours prior to the requested procedure?**	YES	NO

14. Does the patient have:

a) Prosthetic heart valve?	YES	NO
b) History of bacterial endocarditis?	YES	NO
c) History of rheumatic fever and/or cardiac murmur?	YES	NO
d) AV fistula or prosthetic graft/joints for which antibiotics may be required?	YES	NO

15. Patient Allergies: YES NO

Please list:_____

_____

16. Any additional comments concerning patient's medical status?_____

_____

_____

_____

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_____

Form completed by:_____

Please schedule procedure with Dr. Michael Pezzone