

**HARMONY AMBULATORY
SURGERY CENTER, LLC**

Requesting Physician: _____

Please indicate if the patient has any of the following conditions:

- Living in a Nursing Home Congestive Heart Failure Lung disease with the use of Oxygen
 Trouble Swallowing Renal Failure Currently taking Coumadin/Heparin
 Pregnancy

If any of the above conditions are checked, the patient must be seen for an office visit consult. CFG will contact the patient to schedule the office visit.

Date of Request: _____ Patient Name: _____

Patient DOB: _____ Patient Work Phone: _____

Patient (Circle one): Male or Female Patient Home Phone: _____

Patient Address: _____

Insurance Provider: _____ *Best time to contact patient for assessment &*

Insurance Number: _____ *scheduling:* _____

Patient Speaks: English _____ Spanish _____ Other _____

Any GI Physician? or GI Physician Preference: _____

Date of last colonoscopy or flexible sigmoidoscopy: _____

Procedure Requested: (Please Circle) Upper Endoscopy Colonoscopy **Screening Colonoscopy**

Primary Indication for Procedure (check one): Diagnosis Screening (Please note that if the patient has any indications listed below (under Colonoscopy), they cannot be scheduled for a screening.)

EGD
Procedure Indications:
(Please Circle)

Abdominal Pain
GERD
Barrett's
Dyspepsia
Weight Loss
Other: _____

Abnormal Imaging
– Date: _____
Type of Image: _____

COLONOSCOPY
Procedure Indications: (Please Circle)

Abnormal Imaging Study
IBD
Diarrhea
Iron Deficiency Anemia* [*Recommend EGD if colonoscopy (-)]
Hematochezia
Heme + stool
Polyp follow-up
Staging of malignancy–Type: _____

Abnormal Imaging – Date: _____
Type of Image: _____

Colon Cancer Screening:
(Please mark all that apply)

Family History of Colon Polyps or Colon Cancer

Personal History of Colon Polyps or Colon Cancer

Average Risk (Age 50+)

PHYSICIAN / NURSE TO COMPLETE BELOW

ASA Class I or II (Circle one) (If higher, patient <u>does not</u> qualify for this procedure)				Sleep Apnea?	NO	YES		
Antibiotic Prophylaxis?	NO	YES	Previous GI Surgery? (list below)	NO	YES	Renal Failure?	NO	YES
-If Yes, please circle choice below:			_____	CHF?		NO	YES	
VHD <u>or</u> Recent (w/in 1 yr) Vascular Stent			Liver Disease	NO	YES	CAD?	NO	YES
Does patient have Defibrillator*?	NO	YES	Sedation/Anesthesia Difficulty?	NO	YES	COPD?	NO	YES
Does patient have Pacemaker*?	NO	YES	Hypertension?	NO	YES	Insulin Dependent?	NO	YES

**If yes to Pacemaker or Defibrillator, please provide a copy of patient's CRMD card when scheduling.*

Medications: _____

Allergies: _____

Recent relevant labs: _____

Additional pertinent data: _____