Center for Digestive Disorders
BOSTON MEDICAL CENTER

ENDOSCOPY SCHEDULING INFORMATION
MENINO PAVILION
840 Harrison Ave 2nd Floor Endoscopy Center
Fax: 617-638-6359
Phone: 617-638-6525 Option #1 Scheduling
MD to MD 24/7 Consult Page 617-638-7243 ID GUTS (4887)
www.bmc.org/digestivedisorders

☐ **Outpatient** ☐ **Inpatient** ☐ **DOB 4 Patient, Dr:**

Date of Request: _____ **Date of Procedure (Provided by GI):** _____
Patient Name: _____ **Medical Record Number:** _____
Patient Phone #: _____ **Date of Birth:** _____ **Sex: ☐M ☐F**
Patient Address: _____
Insurance Provider: _____ **Insurance #:** _____

Interpreter Services Needed? (Circle) Yes No Language: _____
WAS PREP GIVEN TO THE PATIENT: (Circle) NO YES Type: Golytely Fleet phoshosoda*
***Fleet phosphosoda should not be given to patients with congestive heart failure or renal failure**

Please indicate preferred physician below, otherwise patient will be scheduled with FIRST AVAILABLE
_____ **(preferred M.D.)**

PROCEDURE REQUESTED AND INDICATIONS
COLONOSCOPY
☐ Hematochezia ☐Guaiac Positive ☐ Inflammatory Bowel Disease
☐Iron Deficiency Anemia (EGD will also be done if the colonoscopy is negative). Provide supporting labs: Hgb/Hct: _____ **Ferritin:** _____**Fe/TIBC:** _____ **date:** _____

Colon Cancer Screening
☐Personal History: Polyp Follow-up ☐Personal History: Cancer Follow-up ☐Family History
☐Average Risk (Patients should check with their insurance provider regarding coverage for this procedure)

FLEX SIG
☐ Average Risk (Patients should check with their insurance provider regarding coverage for this procedure)
☐ Hematochezia (Under age 40)

EGD
☐Dysphagia ☐GERD ☐Nausea/Vomiting ☐Hematemesis ☐Dyspepsia

Has patient been instructed to stop coumadin 3-5 days proir to the procedure: ☐ NO ☐YES ☐NA
Has patient been instructed to stop heparin 1 day prior to the procedure: ☐NO ☐YES ☐NA
Does the patient have:
Diabetes ☐NO ☐YES
Sleep Apnea ☐NO ☐YES
If YES, the patient will be referred for a GI office visit to assess the risk for conscious sedation
Congestive heart failure ☐NO ☐YES
Renal failure ☐NO ☐YES
Drug Allergies ☐NO ☐YES : _____
Endocarditis prophylaxis ☐NO ☐YES
(Recommended for patients with a high risk cardiac lesion and EGD w/esophageal dilation or sclerotherapy)

Referring Physicians name (PLEASE PRINT) : _____
Beeper number: _____ Office (tel): _____ FAX #: _____
PCP: _____

The procedure instructions and preparation should be given to the patient and this form should be FAXED.
Approved ☐ By: _____ **PREP:** _____ **Consent: ☐YES☐NO**
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