

The Endoscopy Center of Brookline
SCHEDULING INFORMATION
930 Commonwealth Avenue
Fax: 617-414-6601
Phone: 617-414-6600

Date of Request: _____
Patient Name: _____ Medical Record Number: _____
Patient Phone #: _____ Date of Birth: _____ Sex: M F
Patient Address: _____
Insurance Provider: _____ Insurance #: _____

WAS PREP GIVEN TO THE PATIENT: (Circle) NO YES Type: Halflytely Fleet phoshosoda*
*Fleet phoshosoda 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

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)

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: _____

EGD

Dysphagia GERD Nausea/Vomiting Hematemesis Dyspepsia

Has patient been instructed to stop coumadin 3-5 days prior 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:

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: _____