PENNSTATE HERSHEY
Milton S. Hershey Medical Center

ENDOSCOPY & MOTILITY CENTER OPEN ACCESS SCHEDULING FORM

Completed By (Signature Required) _____ Date _____ Time _____ am pm

FAX: 717-531-0263 PHONE: 717-531-8364
Please visit our web site for additional information and prep instructions: www.pennstatehershey.org/gi

Patient Name: _____ Date of Birth: _____

Phone#: Home: _____ Work _____

Medical Record Number: _____

Address: _____

City: _____ State: _____ Zip: _____

INSURANCE: _____

PMH _____

Medications: _____

_____

Allergies: _____

Referring Physician:
Name: _____
Phone #: _____
Signature: _____
(REQUIRED)
Date _____ Time: _____ am pm

PCP:

NAME: _____
PHONE: _____

IF ANY OF THE FOLLOWING CONDITIONS ARE PRESENT PRE-ENDOSCOPY EVALUATION MAY BE REQUIRED

- ☐ Age>75yrs
- ☐ Defibrillator/Pacer
- ☐ MI in 6mon
- ☐ **Coronary stent**
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ low platelets
- ☐ Hct <30%COPD (Forced Exhaled Volume 1<1.0)
- ☐ Asthma (requiring steroids within last month)
- ☐ On Coumadin/ Heparin/Plavix
- ☐ Artificial heart valve
- ☐ significant psychiatric illness

IF NONE OF THESE CONDITIONS APPLY: please initial _____

PROCEDURE & INDICATION

☐ Colonoscopy ☐ EGD in ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ 1st available

☐ **ANTIBIOTIC PROPHYLAXIS REQUIRED** **Physician to do:** _____ ☐ **any**

- ☐ Melena or Hemoccult+ stool
- ☐ Hematemesis
- ☐ persistent reflux disease
- ☐ Barrett's esophagus
- ☐ Unexplained nausea
- ☐ Barrett's screening
- ☐ Barrett's screening
- ☐ **Anorexia**
- ☐ Failure of therapy
- ☐ Atypical reflux symptoms
- ☐ dyspepsia
- ☐ Screening for varices
- ☐ Gastric ulcer
- ☐ Dysphagia/ Odynophagia
- ☐ Screening colon
- ☐ Constipation
- ☐ Hx polyp / colon Cancer
- ☐ FH polyps/Colon Cancer
- ☐ breast/ovarian cancer
- ☐ Inflammatory bowel disease >8 yrs
- ☐ Rectal bleeding
- ☐ Iron deficiency
- ☐ Anemia
- ☐ Diarrhea
- ☐ Weight loss
- ☐ Abnormal Upper GI/BE\Vomiting
- ☐ Incontinence
- ☐ Abd pain

Other _____

Comments: _____

_____

MOTILITY CENTER PROCEDURE & INDICATION

- ☐ **Esophageal Manometry**
- ☐ **AnoRectal Manometry (ARM)**
- ☐ **Biofeedback**
- ☐ **Electrogastrogram**
- ☐ **(EGG)**
- ☐ BRAVO.....
- ☐ 24hr pH probe....
- ☐ Impedance .....

OFF meds
ON meds
circle one

- ☐ Gastroesophageal reflux
- ☐ Unexplained nausea
- ☐ Dysphagia
- ☐ Atypical reflux symptoms
- ☐ Unexplained dyspepsia
- ☐ Odynophagia
- ☐ Incontinence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Assessment of therapy
- ☐ Chest Pain

***(For scheduler use)* Appointment Date/Time/Notes:** _____

_____

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