PENNSTATE
Milton S. Hershey Medical Center

DIVISION OF GASTROENTEROLOGY AND HEPATOLOGY
ENDOSCOPY & MOTILITY CENTER

OPEN ACCESS SCHEDULING FORM: FAX : 717-531-4914 PHONE: 717-531-8364

Please visit our web site for additional information and prep instructions:www.pennstategastroenterology.com

Patient Name: _____ Ph#: h_____
Date of Birth: _____ w _____
MR number: _____ SS# _____
Address: _____
City: _____State: _____ Zip: _____

Referring Physician:
_____
Phone#
_____
PCP
_____
Phone#
_____

INSURANCE :_____
PMH_____
Medications:_____
_____
Allergies:_____

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

☐ Age>75yrs ☐Defibrillator ☐ MI in 6mon. ☐Stroke ☐ Sleep Apnea ☐ low platelets ☐ HCT <30% ☐COPD (FEV 1<1.0)
☐ Asthma (requiring steroids within last month) ☐ On Coumadin/ Heparin ☐ 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 H+ve stool	☐ Anorexia	☐ Screening colon	☐ Iron deficiency
☐ Hematemesis	☐ Failure of therapy	☐ Constipation	☐ Anemia
☐ persistent reflux disease	☐ Atypical reflux symptoms	☐ H/o polyp / colon Ca	☐ Diarrhea
☐ Barrett's esophagus	☐ dyspepsia	☐ FH polyps/Colon CA	☐ Weight loss
☐ Unexplained nausea	☐ Screening for varices	☐ breast/ovarian cancer	☐ Abnormal UGI/BE
☐ Vomiting	☐ Gastric ulcer	☐ Inflam bowel disease >8 yrs	☐ Incontinence
☐ Barrett's screening	☐ Dysphagia/ Odynophagia	☐ Rectal bleeding	☐ Abd pain

Other……..

Comments: _____

MOTILITY CENTER PROCEDURE & INDICATION

☐ **Esophageal Manometry** ☐ **AnoRectal Manometry (ARM)** ☐ **ElectroGastroGram (EGG)** ☐ **BRAVO**…..... ☐ **OFF meds**
☐ **Biofeedback** ☐ **24hr pH probe**.. ☐ **ON meds**
☐ **Impedance**…….

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

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

Rev.4/5/2007