ENDOSCOPY PATIENT BOOKING & ASSESSMENT FORM

Beacon Hospital

PATIENT DETAILS

Gender: Male ☐ Female ☐
MRN: _____
Surname: _____
Forename: _____
Date of Birth: _____
Phone Number: _____
Email: _____
Address: _____
_____
_____
Next of Kin: _____
NOK Phone no: _____
Insurance Company: _____
Policy/ Member Number:

REFERRING/ ADMITTING DOCTOR

Print Name: _____
IMC number: _____
Signature: _____ **Date:** _____

Please note referral is only valid for 30 days

PROCEDURE DETAILS

Admission Date: _____
Procedure Date: _____
Procedures code:
☐ Colonoscopy (code 455)
☐ Upper GI Endoscopy (code 194)
☐ Flexible Sigmoidoscopy (code 450)
☐ Urea Breath Test
Consumable: Yes ☐ No ☐
Specify:

Pre-Operative assessment: ☐ Yes ☐ No
If yes, Phone ☐ same day ☐ Pre-Op Clinic ☐

Day Case ☐ Procedure Room ☐ Theatre ☐
Inpatient ☐ ICU Bed ☐
Other ☐ Specify:

Allergies: ☐ Yes ☐ No
Latex Allergy: ☐ Yes ☐ No
Infection Alert: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No Type: ☐ I ☐ II

Mobility: ☐ Mobile ☐ Falls Risk ☐ Hoist
Psychosocial History ☐ Yes ☐ No
If yes, specify: _____

UPPER GI SYMPTOMS:

☐ Dyspepsia ☐ Nausea ☐ Vomiting ☐ Dysphagia
☐ Dysphagia ☐ Anemia ☐ Bloating
☐ Reflux/Heartburn ☐ Epigastric Pain

COLORECTAL SYMPTOMS:

Rectal Bleeding: ☐ Acute ☐ Chronic
Altered Bowel Habit ☐ Acute ☐ Chronic
☐ Iron Deficiency Anemia
☐ Abdominal Pain
☐ IBD Assessment / Surveillance / Polyp Surveillance
☐ Abdominal/ Rectal Mass

UPPER GI SCREENING:

☐ Weight Loss ☐ Barrett's
☐ Duodenal Biopsy ☐ Varices Assessment
☐ Hematemesis / Melena ☐ Oesophagus

COLORECTAL SCREENING:

☐ Average Risk (Age<50) ☐ Family History
☐ Adenomatous Polyps ☐ Colorectal Cancer
☐ Haemoccult positive Stool (FIT TEST)

MEDICATIONS:

Anticoagulants ☐ Yes ☐ No
Novel Oral Anticoagulants: ☐ Yes ☐ No
Discontinue prior to admission ☐ Yes ☐ No
Patient informed: ☐ Yes ☐ No
Date of Discontinuation: _____
Relevant Other Medications: _____

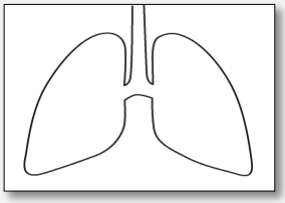
ADDITIONAL INFORMATION:

Fitness for bowel Prep Assessed ☐ Yes ☐ No
MoviPrep prescription provided ☐ Yes ☐ No
Previous endoscopy procedures? ☐ Yes ☐ No
If yes, year _____ Type: ☐ OGD ☐ COLON
Surgical History: _____
_____

MEDICAL HISTORY/ RISK ASSEMENT

Heart Murmurs ☐ Yes ☐ No _____
COPD/Asthma ☐ Yes ☐ No _____
Hypertension ☐ Yes ☐ No _____
ICD/Pacemaker ☐ Yes ☐ No _____
Epilepsy ☐ Yes ☐ No _____
Blood Disorder ☐ Yes ☐ No _____
>85 years ☐ Yes ☐ No _____
High Risk Patient ☐ Yes ☐ No _____
_____

PHYSICAL EXAMINATION HISTORY:



Heart Sounds

Assessment Date: _____

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