



JOHNS HOPKINS
MEDICINE

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BAYVIEW MEDICAL CENTER

**Endoscopy Procedure Referral
Patient Pre-Assessment**

Fax to (410) 550-7861

Patient ID _____

Date: _____

Referring Provider Name: _____ Provider Phone #: _____

Requested Faculty Name: _____

Patient Contact Phone Numbers: Home _____ Work _____

Insurance Type and ID#: _____

PROCEDURE REQUESTED: Colonoscopy _____ Flexible Sigmoidoscopy _____ EGD _____ ERCP _____ Liver Biopsy _____

PROCEDURE INDICATION: _____

ANESTHESIA

- _____ None
- _____ History of alcohol or substance abuse
- _____ Limited neck extension/inability to open mouth

- _____ Intubation Problems
- _____ Previous neck or jaw surgery
- _____ Prior sedation problems

RESPIRATORY

- _____ None
- _____ Asthma
- _____ Chronic Bronchitis
- _____ Oxygen Dependent
- _____ Obstructive Sleep Apnea
- _____ COPD/Emphysema

CARDIAC

- _____ None _____ HTN _____ CHF
- _____ MI/Angina
- _____ Dysrhythmia
- _____ Automatic defibrillator/Pacemaker
- _____ Anticoagulant/Aspirin therapy
- _____ Valvular disease (valve replacement)

ENDOCRINE

- _____ None
- _____ Diabetes

GASTROINTESTINAL/G.U.

- _____ None
- _____ Liver disease
- _____ Kidney disease (CRF/Chronic Renal Insufficiency)

NEUROLOGICAL

- _____ None
- _____ Neuromuscular disease
- _____ Impaired mental status

- _____ Seizures
- _____ CVA/TIA

OTHER PERTINENT INFORMATION:

CURRENT MEDICATIONS (Dosage and Frequency)

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

