Commonwealth Endoscopy Center

120 W. Center Street
W. Bridgewater, MA 02379
508-586-8700
gisdoc.com/endoscopy-center

It is mandatory to have a responsible adult driving you home. A taxi/uber/medical transportation is not allowed unless accompanied by a friend or family member.

The fee for procedures includes services of the gastroenterologist and the use of the facility which are billed as two separate services. Anesthesia and pathology fees will be billed separately as well.

PRE-PROCEDURE ASSESSMENT

PATIENT NAME _____ / REASON FOR EXAM _____

PRIMARY CARE PHYSICIAN _____

PLEASE MARK THE FOLLOWING APPROPRIATELY: **ALLERGIES:** MEDICATION ❒ YES ❒ NO If yes, explain: _____

LATEX ❒ YES ❒ NO _____

PERSONAL HISTORY (SELF)	YES	NO	**EXPLANATION, IF YES**
HEART DISEASE / MURMER / HEART ATTACK			
ANGINA			
HIGH BLOOD PRESSURE			
BLEEDING/CLOTTING PROBLEMS			
BREATHING/LUNG PROBLEMS			
SEIZURES/STROKES/EPILEPSY			
ANEMIA			
LIVER/KIDNEY DISEASE			
HISTORY OF CANCER (SELF)			
DIABETES			
THYROID PROBLEMS			
ARTHRITIS/LIMITATIONS OF MOVEMENT			
IMPLANTED PACEMAKER / DEFIBRILLATOR			
PREGNANT			
DIARRHEA/CONSTIPATION			
TROUBLE SWALLOWING/FOOD STICKING			
SMOKE/DRINK ALCOHOL -- IF YES, AMOUNT			
RECREATIONAL DRUG USE			
PAST SURGICAL HISTORY _____			
_____			
_____			
OTHER _____			

Have you or any family member experienced problems with anesthesia or sedation? _____ NO _____ YES, EXPLAIN

_____

**** DO NOT STOP ASPIRIN**

**** UNLESS OTHERWISE DIRECTED BY THE DOCTOR, TAKE ALL YOUR MEDICATIONS**

**** PLEASE REVIEW THE INSTRUCTIONS YOU RECEIVED FROM YOUR DOCTOR'S OFFICE.**

**** NO IBUPROFEN / ARTHRITIS PRODUCT OR PRODUCTS CONTAINING THESE FOR THREE DAYS PRIOR TO THE PROCEDURE WITHOUT PHYSICIAN APPROVAL.**

**** IF YOU USE INHALERS, BRING THEM WITH YOU THE DAY OF YOUR PROCEDURE**

*** PLEASE FILL OUT MEDICATIONS ON BACK. TYPED LISTS ARE NOT ACCEPTABLE.**

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Pre Op Nurse Sign: _____

Date: _____

Commonwealth Endoscopy Center Medication Reconciliation Form

PLEASE FILL OUT ALL MEDICATIONS. ATTACHED LISTS ARE NOT ACCEPTABLE.

DATE	MEDICATION	DOSAGE	TIMES	LAST DOSE	RESUME MEDICATIONS	COMMENTS

☐ Resume all medications as indicated above

☐Hold the following medication _____for _____ days.

☐ New medications have been added today

☐No new medications have been added.

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Copy Received/Signature of patient_____

Nurse Signature: _____

Date: _____