PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

ENDOSCOPY / G.I. LAB
OUTPATIENT ADMISSION SUMMARY

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM BEFORE COMING TO THE HOSPITAL. (PLEASE PRINT)

Name: _____ DOB: _____ Ht.: _____ Wt.: _____

Procedure: ☐ EGD ☐ Colonoscopy ☐ ERCP ☐ Bronchoscopy ☐ EUS ☐ Motility Study ☐ ph Study ☐ Endo/Anal Ultrasound
☐ Flex Sigmoidoscopy ☐ Peg Tube Insertion ☐ Peg Tube Check ☐ Other: _____

Reason for Procedure: _____

Allergies: _____

List all current medications or attach medication list (Include vitamins, supplements, and over the counter). ☐ None

DRUG	DOSE/AMOUNT	LAST DOSE	DRUG	DOSE/AMOUNT	LAST DOSE

MEDICAL HISTORY

☐ High Blood Pressure ☐ Coronary Artery Disease ☐ Heart Attack ☐ Atrial Fibrillation ☐ Heart Valve Surgery
☐ Pacemaker/Internal Cardiac Defibrillator ☐ Renal Failure If Yes, are you on dialysis: ☐ Yes ☐ No ☐ Asthma ☐ Sleep Apnea
☐ Chronic Obstructive Pulmonary Disease ☐ Diabetes: ☐ Type I ☐ Type II Cancer (type): _____
☐ Infectious Disease (Hepatitis/HIV) ☐ Stroke ☐ Seizure Disorder ☐ Other: _____
☐ Other: _____

List operation(s) and date: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Rarely ☐ Social ☐ Daily ☐ Beer ☐ Wine ☐ Liquor How much? _____

Do you smoke? ☐ Yes ☐ No How much per day? _____

Is there any chance that you could be pregnant? ☐ Yes ☐ No Date of last menstrual period: _____

Have you ever had a reaction to local or general anesthesia? ☐ Yes ☐ No If Yes, please explain: _____

Check if you have any of the following: ☐ Loose Teeth ☐ Caps ☐ Upper Denture ☐ Lower Denture ☐ Hearing Aid
☐ Glasses ☐ Contacts ☐ Hearing Aid ☐ With Patient ☐ Not With Patient

PATIENT LABEL AREA

St Luke's
UNIVERSITY HEALTH NETWORK

ENDOSCOPY / G.I. LAB
OUTPATIENT ADMISSION SUMMARY

RESPONSIBLE PERSON MUST BE PRESENT AT DISCHARGE TO DRIVE YOU HOME

Name of Driver: _____ Relationship: _____

In Waiting Room: ☐ Yes ☐ No Will Return At: _____

Contact Number of Driver: Home/work: _____ Cell: _____

Phone number where you can be reached the next day for a follow-up phone call from the GI Lab Staff:

_____

Last Food Intake: Solid: Date: _____ Time: _____ Liquids: Date: _____ Time: _____

Prep (if having colonscopy): ☐ Completed ☐ Not Completed Color/consistency of bowel movement: _____

Do you feel safe at home? ☐ Yes ☐ No

Do you ever feel the urge to harm yourself? ☐ Yes ☐ No

Do you have any pain? ☐ Yes ☐ No

If Yes, Pain Level (scale 1-10): _____

Description of pain: _____

☐ Referred to family physician

Form completed by: _____ Relationship if other than patient: _____

Nurse Signature: _____ **Date:** _____ **Time:** _____

TO BE COMPLETED BY GI LAB STAFF

LEARNING

Indicate Readiness to Learn (check all that apply): ☐ Receptive ☐ No Interest ☐ Denial ☐ Refused ☐ Mental State ☐ Request Delay ☐ Emotional State ☐ Uncooperative ☐ Pain ☐ Other (specify): _____

Barriers to Learning: ☐ None ☐ Cognitive ☐ Motor ☐ Language ☐ Communication ☐ Culture/Religion ☐ Economic ☐ Literacy/Education ☐ Sensory ☐ Other (specify): _____

Preferred Learning: ☐ Demonstration ☐ Written ☐ Video ☐ Verbal ☐ Other (specify): _____

EDUCATION

Education Completed On (check all that apply): ☐ Disease/Condition ☐ Medications ☐ Further Treatment/Follow-Up ☐ Treatment/Procedure ☐ Equipment/Supplies ☐ Other (specify): _____

Teaching Method: ☐ Verbal ☐ Audio-Visual ☐ Teach-Back ☐ Written ☐ Demonstration

Person Taught: ☐ Patient ☐ Family Member ☐ Other (specify): _____

Evaluation of Learning: ☐ Verbalized/Demonstrated ☐ Needs Reinforcement ☐ Unable to Learn

Nurse Review/Instruction By: _____ Date: _____ Time: _____

Follow Up Phone Call Assessment:

☐ First Attempt Signature: _____ Date: _____ Time: _____ ☐ Left message

☐ Second Attempt Signature: _____ Date: _____ Time: _____ ☐ Left message

Comments: _____

_____

_____