

Rawish J. Mahajan, M.D.
Board Certified in Gastroenterology

Your doctor has requested that you undergo one of the following procedures by open-access endoscopy (direct endoscopy, without clinic visit):

- () EGD (upper endoscopy)
- () Colonoscopy (lower endoscopy)
- () EGD and colonoscopy

Please **complete** the enclosed new patient forms (direct endoscopy patient forms) and *mail them or fax them back to us. Please include photocopies of both sides of your insurance card and driver's license. On receiving the completed forms, procedure instructions will be mailed to you.* Alternatively, you can bring these forms to our office between 8.30 am-11.30 am and pick up instruction sheet for the procedure.

Screening colonoscopy (even in the absence of symptoms) is recommended beginning at age 50 (earlier, if family history of colon cancer). Please check with your insurance carrier if it is a covered benefit for you. Colonoscopy, though the best test available at present, is not perfect in diagnosing colon polyps and cancer.

Our office hours are 8.00 am to 5 pm. Best time to call is 8.30am – 11.30 am. Procedures scheduled in this manner are not meant to be formal consultations. If you are having significant symptoms and wish to have office consultation first, please call 765-807-0531. **If you continue to have symptoms after the procedure, I would like to see you in the office.**

You will receive conscious sedation (twilight sleep) for your procedure. **You will need some one to drive you home after the procedure.** (You may not take public transportation/cab to go home). Please give few dates which work best for you:

First choice: _____ Second choice: _____

Third choice: _____ Fourth choice: _____

Please circle your preference: Morning / Afternoon

5 Executive Drive, Suite B-1, Lafayette, IN 47905
Phone (765)807-0531 Fax (765)807-0534
A Unity Healthcare, LLC Partner



UNITY Healthcare
Notice of Privacy Practices for Protected Health Information
Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Request for Limitations and Restrictions of Protected Health Information (This only pertains to how our office communicates with you.) PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: _____ Date of Birth: _____

It is the office policy of Ravish J. Mahajan, M.D., and staff not to release confidential and/or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence, unless permission is granted as shown below. Information also will not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following (*We can reach you in an emergency, if we have your cell phone number*):

I hereby authorize Ravish J. Mahajan, M.D., and/or his staff, to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the doctor's office whenever this information changes:

			<u>Phone Number</u>
Home Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Answering Machine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Work Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Voice Mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cell Phone and/or mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pager:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Please list the names of authorized people:

Spouse: _____

Parent: _____

Other (*please list name & relationship*): _____

Other (*please list name & relationship*): _____

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

FINANCIAL INTEREST DISCLOSURE

Unity Healthcare, LLC ("Unity") holds an investment interest in certain bonds which were issued for financing health care facilities of St. Elizabeth Regional Health. St. Elizabeth Regional Health is owned and operated by the Sisters of St. Francis Health Services, Inc ("SSFHS"). You are free to determine which facility to utilize for health care services and neither Unity nor your physician will discriminate in the care provided to you should you desire to use a non-SSFHS facility.

Please acknowledge your receipt of this disclosure by signing below.

By: _____ **Relation to pt:** _____ **Date:** _____
Patient, or in case of minor, patient's guardian

PATIENT HISTORY FORM

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Date: _____

Name: _____

• Past Medical History	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
CAD, MI (heart disease) MVP	<input type="checkbox"/>	<input type="checkbox"/>
COPD, lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high BP)	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyp	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries	Yes	No
Partial hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Complete hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder	<input type="checkbox"/>	<input type="checkbox"/>
Appendix	<input type="checkbox"/>	<input type="checkbox"/>
Cesarean section	<input type="checkbox"/>	<input type="checkbox"/>
Lysis of adhesions	<input type="checkbox"/>	<input type="checkbox"/>
Bladder tack	<input type="checkbox"/>	<input type="checkbox"/>
Inguinal hernia (groin)	<input type="checkbox"/>	<input type="checkbox"/>
CABG (cardiac bypass)	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>
Gastric bypass	<input type="checkbox"/>	<input type="checkbox"/>
Colon resection	<input type="checkbox"/>	<input type="checkbox"/>

List other Medical history: _____

List other surgeries: _____

• Family History	Relation	Yes	No	Relation	Yes	No	
Chronic hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's, colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Liver cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
PUD	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other gastro cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syn	_____	<input type="checkbox"/>	<input type="checkbox"/>

Other relevant family history: _____

• Social History	Yes	No	Yes	No	
Tobacco	Currently? <input type="checkbox"/>	<input type="checkbox"/>	Alcohol use:	<input type="checkbox"/>	<input type="checkbox"/>
	Quit date _____		Oz. per week _____	Quit date _____	
	Packs per day _____		Alcohol or drug rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>
	Total # years _____		Date _____		
Diet history	Low fat <input type="checkbox"/>	<input type="checkbox"/>	Last Menstrual Period _____		
	Diabetic <input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
	Salt restricted <input type="checkbox"/>	<input type="checkbox"/>			

Medications: (List name, dosage, directions) PLEASE BRING ALL OF YOUR MEDICATION BOTTLES FOR EVERY APPOINTMENT

Occupation: _____

Previous upper endoscopy: Yes / No Date: _____

Previous colonoscopy : Yes / No Date: _____

Problems with sedation : Yes / No Date: _____

Findings on endoscopy : _____

History of endocarditis Yes No

Prosthetic heart valve Yes No

Recent vascular graft (<1 yr) Yes No

Recent joint replacement (<1 yr) Yes No

Allergies: _____

Medicine allergies: _____

Patient Signature

Nurse Signature

R. Mahajan, M.D. (reviewed)

Date reviewed

