LAFAYETTE SURGICAL CLINIC
ENDOSCOPY REFERRAL / SCHEDULING FORM
(please print legibly!)

Date of Referral: _____

Patient Name: _____

Address: _____
_____

Date of Birth: _____

Phone #: _____

Patient Ht & Wt: _____

Requested Physician:
Smith _____
Summer _____
Francis _____
Jefson _____
True _____
First Available _____

Procedure: _____

Diagnosis: _____

Referring Doctor: _____

	YES	NO
Congenital Heart Disease	____	____
History of Endocarditis	____	____
Heart Valve Surgery	____	____
History of Heart Problems	____	____
Diabetes	____	____
Lung Problems	____	____
Hypertension w/meds	____	____
Home Oxygen	____	____
Kidney Problems	____	____
Dialysis Patient	____	____
Liver Problems	____	____
Coumadin	____	____

Diabetes: w/insulin____ w/o insulin_____

Anti-platelets: _____
_____
_____
(Plavix, Aspirin, NSAIDS)

Reason for Anti-platelets/Coumadin:
_____
_____

Prescribed by: _____

	YES	NO
Personal Hx of Colon Polyps	____	____
Personal Hx of Colon Cancer	____	____
Family Hx Colon Polyps	____	____
Family Hx Colon Cancer	____	____

Date of Previous Endoscopy: _____
(attach copy if available)

List any abdominal surgery/procedures performed:
_____
_____

	Yes	No
Smoker	____	____
Latex Allergy	____	____

Allergies to Medications:
_____
_____

Please list medications below <u>or send list</u> (incl. herbals & OTC's) **or** fax list of meds. Include chart notes/labs if applicable.

_____ _____ _____
_____ _____ _____
_____ _____ _____

<u>PLEASE FAX COMPLETED FORM AND COPIES OF INSURANCE CARDS TO: 765-446-5170</u>

Below to be completed by LSC Staff:

Date of Procedure:_____ Start Time: _____ Length: _____ Location: □ STEE □ USC

Anesthesia Type: □ Local □ IVCS □ MAC □ Drug Order: _____
Sent Info: _____ Insurance _____ Rev. 9/27/17