

1. Patient Information

First Name:					
Last Name:					
Birth Date:		Height:		Weight:	
Primary Care Provider (PCP):				Referral Date:	
Clinic Name:					
What the specialist should focus on:	☐ Procedure with consult following	☐ Procedure without a consult	☐ Consult appointment for evaluation and treatment, and/or for consideration of procedure		
Pharmacy Name:					
Pharmacy Phone:					

2. Medical Devices

Does the patient have a pacemaker or defibrillator ?	☐ YES ☐ NO
Does the patient have any other implanted electronic devices ?	☐ YES ☐ NO

3. Cardiovascular Health

Has the patient had angioplasty, coronary artery bypass graft, stents, heart attack , or been diagnosed with heart failure in the last year ?	☐ YES ☐ NO
Has the patient had any cardiac surgery within the last 6 months , or are they scheduled for any upcoming cardiac procedures ?	☐ YES ☐ NO
Does the patient have any planned cardiac testing for new or uncontrolled symptoms ?	☐ YES ☐ NO
Has the patient been diagnosed with congestive heart failure ?	☐ YES ☐ NO
Does the patient take blood thinners ?	☐ YES ☐ NO

4. Respiratory & Sedation Risk

Is the patient on home oxygen ?	☐ YES ☐ NO
Has the patient had complications with sedation before?	☐ YES ☐ NO
Does the patient have a history of a difficult airway ?	☐ YES ☐ NO
Does the patient use a rescue inhaler ?	☐ YES ☐ NO

5. Liver & Kidney Health

Has the patient been diagnosed with cirrhosis of the liver ?	☐ YES ☐ NO
Has the patient had a liver transplant ?	☐ YES ☐ NO
Does the patient have chronic kidney disease ?	☐ YES ☐ NO
Is the patient currently on dialysis , or is it planned within 12 months ?	☐ YES ☐ NO

6. Other Chronic Conditions	
Does the patient have diabetes ?	☐ YES ☐ NO
Has the patient had a stroke in the last year ?	☐ YES ☐ NO
Has the patient been diagnosed or treated for head, neck, or throat cancer ?	☐ YES ☐ NO
7. Gastrointestinal History	
Has the patient had the same procedure at WAGI or elsewhere ?	☐ YES ☐ NO
Has the patient had poor prep in the past?	☐ YES ☐ NO
Does the patient have chronic constipation (3 or fewer bowel movements per week)?	☐ YES ☐ NO
Does the patient take stool softeners or Miralax daily ?	☐ YES ☐ NO
Has the patient ever tested positive for H. pylori ?	☐ YES ☐ NO
<i>If yes, has it been treated?</i>	☐ YES ☐ NO
Has the patient had a positive FOBT or FIT test ?	☐ YES ☐ NO
8. Surgery History	
Has the patient had any abdominal surgery within the last 3 months ?	☐ YES ☐ NO
9. Reproductive Health	
Is the patient currently pregnant or could the patient be pregnant?	☐ YES ☐ NO
10. Medications & Allergies	
Does the patient take iron or fiber supplements ?	☐ YES ☐ NO
Does the patient take Ozempic, Mounjaro, Wegovy, or other weight loss medications ?	☐ YES ☐ NO
Does the patient take narcotic pain medication ?	☐ YES ☐ NO
Is the patient allergic to any medications ?	☐ YES ☐ NO
<i>If yes, list medications:</i>	
11. Functional & Living Status	
Does the patient have mobility limitations ?	☐ YES ☐ NO
Does the patient need assistance moving from wheelchair to bed ?	☐ YES ☐ NO
Is the patient in an Assisted Living Facility ?	☐ YES ☐ NO
Can the patient walk up a flight of stairs without stopping or experiencing shortness of breath, chest pain, or tightness ?	☐ YES ☐ NO
12. Transportation & Communication	
Will the patient be using a private vehicle with a driver ?	☐ YES ☐ NO
Will the patient be using Uber, Paratransit, Shuttle, Taxi, Lyft, Hopelink , or other non-private transportation ?	☐ YES ☐ NO
Does the patient require an interpreter ?	☐ YES ☐ NO
<i>If yes, what language?</i>	
13. Recent Infections	
Has the patient been diagnosed with COVID-19 recently ?	☐ YES ☐ NO