

Capsule Endoscopy Intake Form

NEW PATIENT _____	EXISTING PATIENT _____	CALL PATIENT _____	PATIENT WILL CALL _____
Date: _____		Age: _____	
Patient Name _____		Referring MD _____	
Address _____		Address _____	
City/State/Zip _____		City/State/Zip _____	
Tel# Home _____		Work _____	
DOB _____		SS# _____	

Type of Appointment

Consult _____	Capsule Endoscopy _____
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Telephone History

1. Do you have a history of bowel obstruction?	Y N
2. Have you had bowel or intestinal surgery?	Y N
Type of surgery: _____	Any complications? _____
3. Have you had abdominal radiation therapy?	Y N
4. Have you previously had a capsule endoscopy or swallowed any other ingestible device?	Y N
5. Do you take insulin? (dose: _____)	Y N
6. Have you ever taken NSAIDs, such as Advil or Indocin, or aspirin for more than 30 days?	Y N
7. Do you have a pacemaker?	Y N
8. Do you have a history of Crohn's disease?	Y N
A YES answer to any of the above questions should be brought to MD's attention.	
9. Have you seen Dr. _____ before? (when: _____)	
10. Are you exposed to any type of radiofrequency between 430 and 439?	

Tell Patient

1. Capsule endoscopy is contraindicated in patients with bowel obstruction, pregnancy, and in patients with a pacemaker or defibrillator.
2. Have to come NPO for min. 8 hours and remain NPO for 2 hours after swallowing the capsule. They may eat light meal 4 hours after swallowing the capsule.
3. Have to wear belt for 8 hours and return to office to have the belt removed.
4. Do not have MRI during capsule procedure.
5. Do not take iron products for 1 week prior to exam.
6. Bring abdominal x-rays taken within the last year with you.

Billing

Fee quoted? Y N	Amount: _____	Medicare _____ Non-Medicare _____
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Scheduling

Date: _____	Day: M T W Th F	Time: _____
Entered in Appointment Book Y N	Appointment made by: _____	