



### Procedure Financial Disclosure

You have been scheduled for a colonoscopy: CPT Code: \_\_\_\_\_ and/or an Upper Endoscopy (EGD):CPT: 43235 on \_\_\_\_\_ at

- Pikes Peak Endoscopy Center
- Briargate Endoscopy Center
- MemorialMain
- Memorial North

The indicating diagnosis for this procedure is \_\_\_\_\_. The diagnosis code(s) submitted on the claim for the procedure will indicate the actual findings of the procedure. (i.e., what may have been scheduled as a screening, could change to diagnostic due to the findings during the procedure.)

If you are having your procedure performed at Pikes Peak Endoscopy Center or Briargate Endoscopy Center, we are Medicare certified free-standing ambulatory surgical centers owned by the physicians of Gastroenterology Associates of Colorado Springs (GACS). **GACS physicians do not perform "office based" endoscopy services. Therefore, office visit co-pays will not apply for these services.**

Endoscopy services are surgical procedures and will be processed under the surgical provisions of your insurance plan. Some insurance plans have exclusions for out-patient surgical procedures or have different out-of-pocket expenses based on the location where the procedure is performed. Individual and Family deductibles may apply. While the procedures are diagnostic in nature, they are not considered a diagnostic test by the insurance carrier, nor the American Medical Association.

Our Pre-Cert Specialist will contact your insurance plan to see if pre-certification is required for the procedure. Please note that pre-certification is not a guarantee of payment as per your insurance company.

As a courtesy to our patients, we will attempt to find out what your benefits will be, however, all insurance companies specify that the information they provide to us does not guarantee payment or that the amounts they quote us due by the patient will be the same after the claim is processed. You are responsible for additional deductibles, co-pays or any co-insurance your insurance company may assess to your responsibility. Services not covered or deemed not medically necessary by your plan will be your responsibility. **We strongly encourage you to call your insurance carrier to understand what your benefits are for the procedure that has been scheduled.** We do have a cancellation policy and fee associated with the cancellation of procedures if we are not notified within the specified time period. It is your responsibility to understand what your coverage is and if you have questions regarding your coverage, you should contact your insurance company. You will need to provide them the information listed in the first section above. Be sure to have them review the "indicating" diagnosis as some plans have limited coverage based on diagnosis, or difference in coverage for screening vs. diagnostic procedures.

**If you have not already done so**, you will need to provide us with your correct insurance information at least 14 days prior to your scheduled procedure to allow time for pre-certification. You need to be sure we have your primary, secondary (and tertiary) insurance information as all may require pre-certification. Call (719) 632-7101, and follow the prompt for the appropriate physician that will be performing your procedure to report updated insurance information. Failure to report the correct updated insurance information prior to the procedure may result in you being responsible for the full balance due. If you present a different insurance at the time of check in for your procedure, your procedure may be rescheduled to a future date that allows us to complete the pre-certification process.

The procedure for which you are scheduled generates the following fees and will be billed separately: (1) a professional fee for the physician's services, (2) a facility fee for use of the surgery facility, and (3) if a tissue biopsy is required, a fee for pathology services from the pathologist/lab.

- Please bring this signed form with you on the day of your procedure**
- Please mail this form back to our office (address below) 4-5 days prior to your procedure**

**Gastroenterology Associates of Colorado Springs, L.L. P./Pikes Peak Endoscopy and Surgery Center L.L.C./Briargate Endoscopy Center, L.L.C.**

***Acknowledgement of Receipt of Procedure Financial Disclosure***

I have received a copy of the Procedure Financial Disclosure for Gastroenterology Associates of Colorado Springs, LLP.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



**FINANCIAL POLICY AND PATIENT AGREEMENT**

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Gastroenterology Associates of Colorado Springs, LLP, Pikes Peak Endoscopy & Surgery Center, LLC and Briargate Endoscopy Center, LLC. Please be advised that Pikes Peak Endoscopy & Surgery Center and Briargate Endoscopy Center are owned and operated by the physicians of Gastroenterology Associates of Colorado Springs, LLP and are fully certified Medicare approved and licensed by the state of Colorado.

**CUSTOMER SERVICE:** If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (719) 477-0755. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a \$25.00 service charge on all returned checks.

**APPOINTMENTS:** Please arrive at least 30 minutes prior to your appointment to give yourself time to update your records or complete paperwork required by your insurance. In order to meet the needs of all our patients, please call us immediately if you have to reschedule your appointment so that we can accommodate another patient's needs. If you fail to cancel or reschedule within **24 hours of your office visit**, you will be billed \$25.00 for that visit. If you fail to cancel or reschedule within **72 hours of your scheduled procedure**, you will be billed \$50.00 for that missed procedure appointment.

**INSURANCE FILING:** As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).

**HMO/PPO:** If we have an agreement with your insurance carrier, we will receive direct payment for covered services. Co-payments are due at the time of service. Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and is your responsibility to obtain one. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. If you are having a procedure performed at Pikes Peak Endoscopy & Surgery Center or Briargate Endoscopy Center and a pre-certification for that procedure is required, we will obtain authorization for that procedure on your behalf. If your insurance company does not authorize the procedure, you will be notified of your financial responsibility prior to the procedure being performed.

**INDEMNITY-TYPE INSURANCE:** Your insurance may or may not agree with the UCR (usual, customary and reasonable) charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. You will be responsible for any remaining balance on your account once your insurance has processed our claim.

**Billing Statements:** Our statements are sent monthly. We allow 60 days for your insurance company to respond to our claim. If they have not responded in that time frame, we will send you a bill for the outstanding amount and ask that you begin making payments on your account while you resolve any payment issues with your insurance company.

**Copies of Medical Records:** We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. We do not charge patients for copies of their own records. Fees for copying records requested from business' are as follows: \$14.00 for 10 or fewer pages, 50 cents per page for pages 11-40 and 33 cents per page after 40 pages.

By signing below, I am recognizing that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## MIRALAX BOWEL PREPARATION INSTRUCTIONS

### ONE WEEK BEFORE THE PROCEDURE:

- You **must** speak with your primary care physician or a specialist before your scheduled colonoscopy if you are taking **Coumadin (Warfarin), Plavix (Clopidogrel Bisulfate), Ticlid (Ticlopidine hydrochloride), Dabigatran (Pradaxa), Effient (Prasugrel) or any other Blood Thinners**. You may need to stop these medications a week prior to your procedure. You may continue taking a daily aspirin.
- It is important to continue to take all other prescribed medications.** On the day of the procedure, you may take your prescribed medications with a small sip of water up to two hours before your procedure.
- Buy:**
  - ONE (1)** bottle of Miralax (available at grocery or drug store over the counter in the laxative section) in either 238 or 255 gram bottles.
  - Bisacodyl 5mg tablets (any brand i.e. Dulcolax/Fleet/Corretol) – **LAXATIVE, NOT STOOL SOFTENER** (available at grocery or drug store over the counter in the laxative section).
  - Two 64 Oz bottles of G2 Gatorade, Gatorade, Pedialyte or Powerade. (no red/purple/blue)
  - Baby Wipes, Depends, Desitin or A & D ointment (optional)



You must stop drinking 2 hours before your procedure or the procedure will be cancelled or delayed



### TWO DAYS BEFORE THE PROCEDURE:

- Start Low Residue Diet – See attached list of examples

### THE DAY BEFORE THE PROCEDURE:

- 7:00AM**—Start the “Clear Liquids Diet” (**listed on the next page**) and continue the entire day. Do **NOT** eat solid foods or drink thick liquids all day.
- 2:00PM** - Take 4 **Dulcolax (bisacodyl)** tablets orally.
- 4:00PM-6:00PM** – Mix half (1/2) the **bottle of Miralax** with 64 oz of Powerade or Gatorade. Drink one glass every 15-20 minutes until gone (approximately 1 ½ to 2 hours), or as quickly as you can tolerate it. If your schedule allows it is preferred to take the prep as early as 4:00PM. Please note that it may take 6 or more hours to begin having bowel movements. **If you have problems with constipation, we suggest starting the Miralax even earlier (start at 2:00pm) to allow more time for it to pass.**

### THE DAY OF THE EXAM:

- 4-6 hours before the scheduled time of your procedure** – Mix the other half of the **bottle of Miralax** with the second 64 oz of Powerade or Gatorade and drink as you did the night before. Continue to drink clear liquids until 2 hours prior to your procedure.



You **MUST** stop drinking 2 hours before your procedure or the procedure will be cancelled or delayed.

- Note:** Individual responses to laxatives do vary. This prep may cause multiple bowel movements. It can work within 30 minutes but may take as long as 7 hours. Please remain within easy reach of toilet facilities.
- Some patients find it helpful to use Desitin or A&D ointment, and use baby wipes or personal cleansing cloths (instead of toilet paper) to avoid irritation from frequent wiping.

## **LOW RESIDUE DIET—TWO DAYS PRIOR TO YOUR PROCEDURE**

**Allowed: soup, fish, white meat chicken, eggs, white rice, bread, cracker, plain yogurt (limit 2 cups), clear fruit juices, clear beverages, noodles, potato with no skin, broth, bouillon, gelatin, fruit ice, popsicle, jelly, salt, pepper, sugar**

**Avoid: fruit skins or seeds, all vegetables, raisins, fresh and dried fruit, nuts, seeds, cloves, marmalade**

## **CLEAR LIQUID DIET - ONE DAY PRIOR**

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed.

**NO RED, BLUE, OR PURPLE LIQUIDS SHOULD BE CONSUMED!**

<b>FOOD GROUP</b>	<b>FOODS ALLOWED</b>	<b>FOODS TO AVOID</b>
Milk & beverages	Tea (decaffeinated or regular), carbonated beverages, fruit flavored drinks	Milk, milk drinks
Meats & meat substitutes	None	All
Vegetables	None	All
Fruit & fruit juices	Strained fruit juices: apple, white grape, lemonade, pulp free orange juice	Fruit juices with unstrained fruit
Grains & starches	None	All
Soups	Clear broth, consommé	All others
Desserts	Clear flavored gelatin, popsicles	All others
Fats	None	All
Miscellaneous	Sugar, honey, syrup, clear hard candy	All others

You may drink vanilla or chocolate Boost/Ensure the day before your procedure until your prep is started if extra caloric intake is needed.

## **SAMPLE DIET**

### **BREAKFAST**

White grape juice  
Clear broth  
Jell-O®  
Tea/Coffee

### **LUNCH**

Apple Juice  
Clear broth  
Jell-O®  
Tea/Coffee

### **DINNER**

Lemonade  
Clear broth  
Jell-O®  
Tea/Coffee

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# Colonoscopy

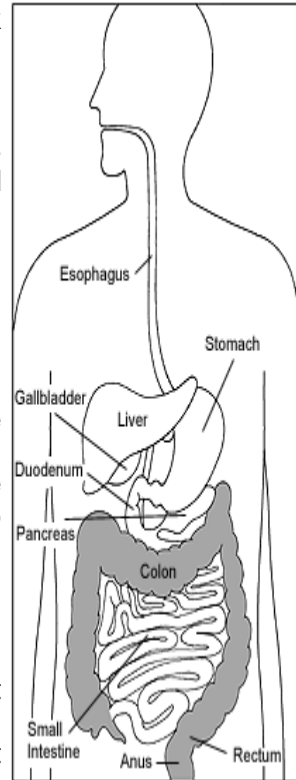
**Colonoscopy:** Colonoscopy (koh-luh-NAH-skuh-pee) lets the physician look inside your entire large intestine, from the lowest part, the rectum, all the way up through the colon to the lower end of the small intestine. The procedure is used to diagnose the causes of unexplained changes in bowel habits. It is also used to look for early signs of cancer in the colon and rectum. Colonoscopy enables the physician to see inflamed tissue, abnormal growths, ulcers, bleeding, and muscle spasms.

For the procedure, you will lie on your left side on the examining table. You will probably be given pain medication and a mild sedative to keep you comfortable and to help you relax during the exam. The physician will insert a long, flexible, lighted tube into your rectum and slowly guide it into your colon. The tube is called a colonoscope. The scope transmits an image of the inside of the colon, so the physician can carefully examine the lining of the colon. The scope bends, by turning dials on the handset, the physician can move it around the curves of your colon. You may be asked to change position occasionally to help the physician move the scope. The scope also blows air into your colon, which inflates the colon and helps the physician see better.

If anything unusual is in your colon, like a polyp or inflamed tissue, the physician can remove a piece of it using tiny instruments passed through the scope. That tissue (biopsy) is then sent to a lab for testing. If there is bleeding in the colon, the physician can pass a laser, heater probe, or electrical probe, or inject special medicines, through the scope and use it to stop the bleeding. Bleeding and puncture of the colon are possible complications of a colonoscopy. However, such complications are uncommon.

The procedure can take up to 30 minutes and possibly longer if there are abnormal growths, inflamed tissue, ulcers, or bleeding. The sedative and pain medicine should keep you from feeling much discomfort during the exam. You will remain in recovery for a period of time until some of the sedative wears off. The sedative can cause you not to retain the discharge instructions provided by the discharge nurse, we recommend you have someone in your room with you to receive those instructions at the time of discharge so they can go over them again with you when you get home.

**Preparation:** Your colon must be completely empty for the colonoscopy to be thorough and safe. You have been provided instructions you should **read 1 WEEK** prior to your procedure as there are special directions that may require you to stop certain medications (with your doctor's approval) one week before and a special diet you must start the day before your procedure. Also, you must have someone come with you to stay during your procedure and drive you home afterward—you will not be allowed to drive because of the sedatives.



1699 Medical Center Pt  
Colo Spgs, CO 80907  
(719)632-7101  
www.GACSONline.com



1699 Medical Center Pt  
Colo Spgs, CO 80907



4110 Briargate Pkwy  
Suite 100  
Colo Spgs, CO 80920

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## DIABETIC INSTRUCTIONS

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### INSULIN DEPENDENT

- THE MORNING BEFORE YOUR SCHEDULED TEST: take your normal AM dose of insulin.
- IF YOU TAKE AN AFTERNOON DOSE: Take ½ of your normal dose the afternoon before your test.
- THE MORNING OF YOUR TEST: Take ½ of your normal AM dose.
- DO FINGER STICKS AS NEEDED
- BRING YOUR INSULIN WITH YOU THE DAY OF YOUR PROCEDURE

### PILL DEPENDENT

- THE MORNING BEFORE YOUR SCHEDULED TEST: Take your normal dose of pills.
- DO NOT TAKE ANY MORE PILLS UNTIL AFTER YOUR PROCEDURE IS DONE.
- IF YOU TAKE INSULIN AND PILLS PLEASE FOLLOW ALL OF THE ABOVE INSTRUCTIONS.

### DIET DEPENDENT

- FOLLOW PREP INSTRUCTIONS AS GIVEN



### PREP INSTRUCTIONS

- WHEN MIXING MIRALAX USE 64 OZ OF G2 GATORADE VS PLAIN GATORADE IT HAS LESS SUGAR (NO PURPLE, BLUE OR RED)

YOUR NURSE WILL DO A FINGER-STICK WHEN YOU ARRIVE FOR YOUR PROCEDURE.

IF YOU HAVE ANY QUESTIONS PLEASE CALL 632-7101 AND SPEAK TO A MEDICAL ASSISTANT.

Memorial Health System  
**INFORMED CONSENT FOR OPERATION OR PROCEDURE**

Print Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

I authorize \_\_\_\_\_ to perform the following procedure: (NO ABBREVIATIONS/ACRONYMS)  
\_\_\_ Right \_\_\_ Left \_\_\_ NA

I understand the reason for the procedure is: \_\_\_\_\_

No guarantee or assurance has been made to me as to the results of the procedure.  
I also authorize any additional procedures deemed necessary due to unsuspected conditions found during the procedure.

**ALTERNATIVES:** \_\_\_\_\_

**RISKS:** Any procedure involves some risks and hazards. The most common risks of surgery include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia or death. Additional risks of this procedure include but are not limited to: \_\_\_\_\_

- The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.
- Other qualified medical practitioners may perform important tasks in my procedure (i.e. opening, closing, removing tissue, administer anesthesia) based on their scope of practice under the direct supervision of my physician.
- Medical observation or participation may occur during my procedure by healthcare team members, students and designated sales representatives under the direct supervision of my physician.
- Any tissue or hardware removed will be disposed of safely by the hospital.
- Memorial Health System will release applicable health information to device manufacturer(s) per state and/or federal regulations in order to track any implanted device in case of a recall or failure.
- Photographing/videotaping may be done for the purpose of diagnosis and/or treatment as determined by my physician.  
(Photography for educational purposes requires a separate consent)

- A. \_\_\_ NA \_\_\_ I agree \_\_\_ I do not agree to authorize healthcare student(s) to participate in my procedure
- B. Moderate sedation: \_\_\_ NA \_\_\_ I agree \_\_\_ I do not agree to the use of moderate sedation based on the explanations of the risks, benefits and expected results of this type of sedation. \_\_\_ Per Anesthesia recommendation
- C. Allograft/xenograft: \_\_\_ NA \_\_\_ I agree \_\_\_ I do not agree to the use of allograft/xenograft based on the explanations of the risks, benefits and expected results of its use. (See information sheet)
- D. Blood transfusion: \_\_\_ NA \_\_\_ I agree \_\_\_ I do not agree to the use of blood or blood products during and after the procedure as needed based on the explanations of the risks, benefits and expected results (See information sheet)

**PATIENT CONSENT:** I understand the information my physician/LIP gave me. I was given the opportunity to ask further questions.

Signature of Patient or Legal Surrogate: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

**PHYSICIAN or LIP DECLARATION:** I have explained the operation/procedure, anticipated benefits indications, alternatives, and material risks pertinent to this procedure. I have answered my patient's questions. The patient has been adequately informed and has consented.

Signature of Physician or LIP: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**INTERPRETATION:** This form was interpreted for the patient /representative in \_\_\_\_\_ language by operator # \_\_\_\_\_

NA = Not Applicable  
Page 1 of 2

  
Memorial Health System  
1400 East Boulder Street  
Colorado Springs, CO 80909

2-18-11  
1200029  
This Consent is available in Spanish and the content is identical  
Timeout Conducted: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Signature: \_\_\_\_\_

MUST PLACE ID LABEL  
IN THIS BOX ONLY

# SEDATION / MODERATE

Patient's Name \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

Instructions: **Must** complete section A, D and E. Complete B & C if H+P not done.

**A:**  H+P completed within 30 days and present on chart. Has there been any change in patient's health status?  
 No  Yes, explain \_\_\_\_\_  
 If no H+P on chart from today, complete sections B and C  
 Reviewed Health Questionnaire (For Outpatient GI, Endoscopy, & Radiology only)  
**Indications:** \_\_\_\_\_

**B:**

Medical History	No	Yes	Explain	Medication Name	Dose	Frequency	Comments
Hypertension							
Heart Disease							
Lung Disease							
Neuro Disease							
Diabetes							
Renal Disease							
Bleeding Disorder							
ETOH/Substance Abuse							
Anes./Sed. Complications							
Hx stridor, apnea, snoring							
Pain control problems							
Other							

Allergies: NKA or update composite list  
Pregnancy/LMP \_\_\_\_\_

**C: Patient Physical Exam**

**Vital Signs:** (BP, HR, RR, baseline SpO2) Weight \_\_\_\_\_  
See Nurses Notes \_\_\_\_\_

<b>General</b>	<input type="checkbox"/> No acute distress <input type="checkbox"/> Well developed, well nourished
<b>Pulmonary</b>	<input type="checkbox"/> Clear bilaterally
<b>Cardiac</b>	<input type="checkbox"/> Regular rate + rhythm <input type="checkbox"/> Able to lie flat
<b>Abdomen</b>	<input type="checkbox"/> Soft <input type="checkbox"/> BS+ <input type="checkbox"/> Non-tender
<b>Neuro</b>	<input type="checkbox"/> A&O to time, place person (age appropriate)
<b>Airway</b>	<input type="checkbox"/> Opens mouth normally <input type="checkbox"/> Neck - normal mobility without pain
<b>Other</b>	

**D: Anesthesia Classification**

Check Anesthesia Classification below:  
 Anesthesia Consultation  Yes  No

**Class 1.** Normal healthy patient.  
 **Class 2.** Mild systemic disease, which does not limit activity (Examples: well-controlled HTN; well-controlled asthma; well-controlled diabetes mellitus)  
 **Class 3.** Moderate or severe systemic disease, which does limit activity (Examples: poorly-controlled diabetes mellitus; symptomatic respiratory disease [e.g. asthma, COPD]; morbid obesity, stable angina, Obstructive Sleep Apnea (OSA)  
 **Class 4.** Severe systemic disease that is a constant potential threat to life (Examples: debilitating respiratory disease; end stage renal disease, CHF)  
 **Class 5.** Moribund patient who is not expected to survive without the procedure

**E: NPO Time/Date**

Last Food \_\_\_\_\_  
Last Fluid \_\_\_\_\_

**NPO GUIDELINES:**  
 -Clear Liquids - 2 hours  
 -Breast Milk - 4 hours  
 -Formula - 6 hours  
 -Solids - 8 hours  
 (colonoscopy per prep instructions)

**Procedure:** \_\_\_\_\_

Verified by MD / DO: Yes No  
 Marking by MD / DO: Yes N/A  
 Time Out at \_\_\_\_\_ hrs

Initials of all present: \_\_\_\_\_

THE PATIENT HAS BEEN RE-EVALUATED AND IS STILL A CANDIDATE FOR THE PLANNED SEDATION

Date: \_\_\_\_\_ Time: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Airway (patent) \_\_\_\_\_ MD/DO initials: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_



1400 EAST BOULDER STREET  
 COLORADO SPRINGS, CO 80909  
 Sedation Procedure - Physician H & P

## HOME/DISCHARGE MEDICATION PROFILE

**CURRENT Medications/Supplements/Herbals:**

**Patient Instructions:**

1. Complete this section (outlined in blue) with your current medication/supplements/herbal information. Copy the information exactly as printed on your prescription bottles.

**Healthcare Provider Instructions**  
Please indicate medications to be stopped.

At Home or Outpatient Prescriptions and Over the Counter Medications:

Discharge Process for Health Care Provider

Drug Name <small>(List only those MEDS currently being taken)</small>	Route	Dose	Frequency	Reason for Taking	Stop	Comments
1					<input type="checkbox"/>	<input type="checkbox"/>
2					<input type="checkbox"/>	<input type="checkbox"/>
3					<input type="checkbox"/>	<input type="checkbox"/>
4					<input type="checkbox"/>	<input type="checkbox"/>
5					<input type="checkbox"/>	<input type="checkbox"/>
6					<input type="checkbox"/>	<input type="checkbox"/>
7					<input type="checkbox"/>	<input type="checkbox"/>
8					<input type="checkbox"/>	<input type="checkbox"/>
9					<input type="checkbox"/>	<input type="checkbox"/>
10					<input type="checkbox"/>	<input type="checkbox"/>
11					<input type="checkbox"/>	<input type="checkbox"/>
12					<input type="checkbox"/>	<input type="checkbox"/>
13					<input type="checkbox"/>	<input type="checkbox"/>
14					<input type="checkbox"/>	<input type="checkbox"/>

### DISCHARGE MEDICATIONS

MEDICATION <small>(Include Strength)</small>	DIRECTIONS <small>(Dose/Route/Frequency)</small>	Reason <small>(Indication)</small>	NEXT DOSE	LAST DOSE

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Current medications/supplements/herbals list has been reviewed. Recommend continuing as listed, EXCEPT METFORMIN after anesthesia or contrast dye.<br><input type="checkbox"/> Recommend discussing home medications with your primary care physician.<br><input checked="" type="checkbox"/> If your medications have been held or changed, follow up with your Primary Care Physician.<br><input checked="" type="checkbox"/> Bring this form to follow up visits | <input type="checkbox"/> Unable to Obtain Medication History.<br>Reason: _____<br>Data Source: <input type="checkbox"/> Patient <input type="checkbox"/> Family<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Copy given to patient/family |
|---|---|

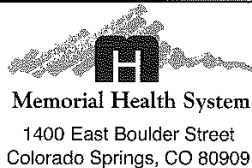
FAXED to Dr. \_\_\_\_\_

Additional medications on Supplemental Page

Pre Surgery RN Signature: \_\_\_\_\_ Date/Time \_\_\_\_\_

Admitting RN Signature: \_\_\_\_\_ Date/Time \_\_\_\_\_

Discharge RN Signature: \_\_\_\_\_ Date/Time \_\_\_\_\_



Patient Label

**ADULT HEALTH QUESTIONNAIRE**  
(PRE-SURGERY / PRE-PROCEDURE)

Name \_\_\_\_\_ Surgery / Procedure \_\_\_\_\_ Current WT \_\_\_\_\_ HT \_\_\_\_\_

Check (Y)es or (N)o for each item: **Y N** Comments:

**Y N** Comments:

Heart Disease If yes, who is your Managing Doctor:			Sleep Apnea If yes, who is your Managing Doctor:		
Heart murmur			Do you snore louder than talking/loud enough to be heard through closed doors		
Chest pain with exercise			Often tired, fatigued or sleepy during the day		
Heart Attack			Has anyone noticed you stop breathing during your sleep		
High Blood Pressure			CPAP/BIPAP		
Do you get short of breath walking 2 flights of stairs			<b>Anesthesia</b>		
Echo/Stress Test/past yr			Jaw Problems		
EKG / past yr			Motion Sickness		
Pacemaker / Defibrillator			Malignant Hyperthermia (you or your family member)		
<b>Lung Disease If yes, who is your Managing Doctor:</b>			<b>Infections</b>		
Cold/Flu last 2 weeks			MRSA (Methycillin Resistant Staph Aureus)		
Emphysema/COPD			VRE (Vancomycin Resistant Enterococcus)		
Asthma			Hepatitis		
Oxygen Use (flow-route)			HIV		
Chest Xray in past year			History of/or active Tuberculosis (TB)		
<b>Diabetes If yes, who is your Managing Doctor:</b>			Rashes, sores, open wounds		
Age Diagnosed			<b>Safety</b>		
Blood Glucose monitoring		Range _____	History of falling in last 3 months		
<b>General Health</b>			Unsteady walk or use of cane/walker		
Bleeding Tendencies			<b>Allergies</b> <input type="checkbox"/> NO, if YES Please complete the following:		
Blood Clots / Phlebitis			Allergies to Medications	Reaction	
Kidney Failure Problems					
Liver Problems					
Ulcers / Acid Reflux					
Rheumatoid Arthritis					
Polio / Multiple Sclerosis					
Spinal Cord / Head Injury					
Seizure Disorder					
Mental Disability					
Cancer			Food Allergies		
Other Medical Problems:			Latex/ Tape		
<b>Social History</b>			Iodine / IV contrast		
Current Smoker			Other:		
# of years smoking / pks Day			<b>Surgery History</b>		
Do you want smoking cessation info			Year	Surgery	Anesthesia Problems
Year you quit smoking					
Alcohol - use / amount					
Recreational drugs					
Do you feel safe at home			<b>PLEASE COMPLETE THE HOME/DISCHARGE MEDICATION PROFILE SHEET</b>		
If not, what do you need					
Last Menstrual Period		____/____/____			

Patient/Responsible Party \_\_\_\_\_ Contact Person / Phone \_\_\_\_\_

PSC RN \_\_\_\_\_ Date \_\_\_\_\_ Admit Nurse \_\_\_\_\_ Date: \_\_\_\_\_

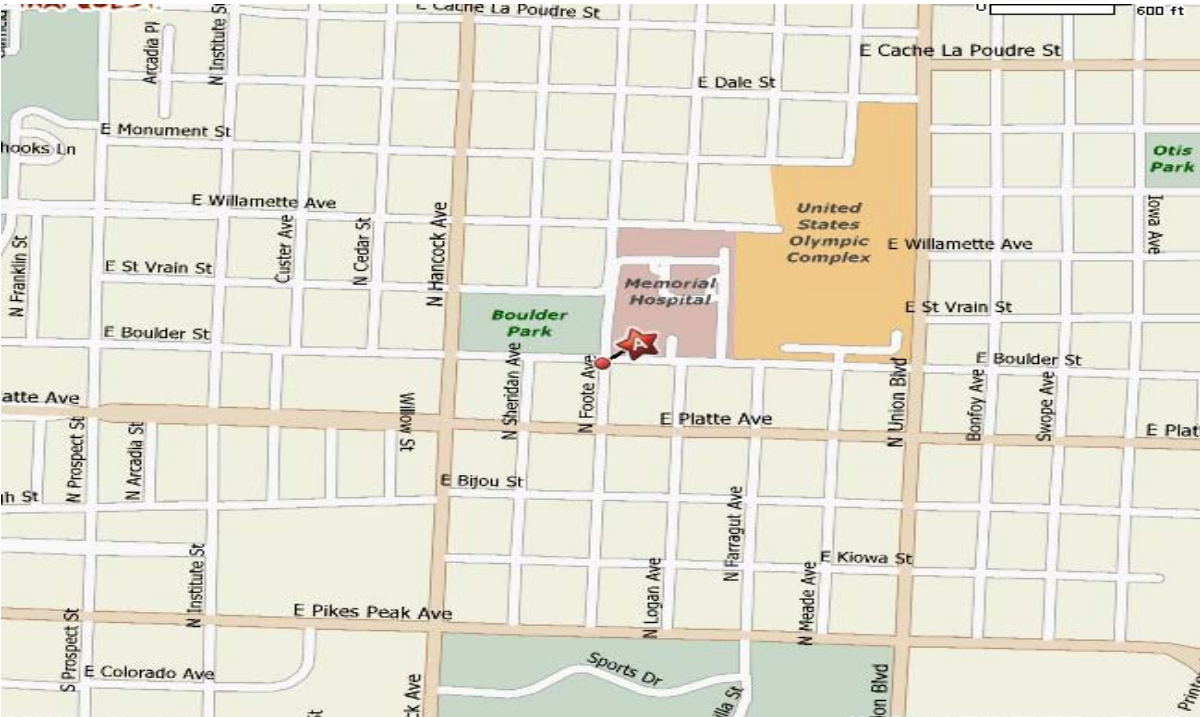


**Memorial Health System**  
1400 East Boulder Street  
Colorado Springs, CO 80909

1250013 (11/2010) Adult Health Questionnaire (Pre-Surgery/Pre-Procedure)

**PATIENT LABEL HERE**

# MEMORIAL HOSPITAL MAPS



**MEMORIAL MAIN 1400 EAST BOULDER STREET**



**MEMORIAL HOSPITAL NORTH 4050 BRIARGATE PARKWAY**