



Procedure Only Questionnaire

Patient coming from: <input type="checkbox"/> Home <input type="checkbox"/> Skilled Nursing Facility/Assisted Living Facility (see tool) <input type="checkbox"/> Rainier School (If yes, schedule at hospital) <input type="checkbox"/> Jail (If yes, schedule at hospital) <input type="checkbox"/> Western State Hospital (If yes, schedule at hospital)	Assisted Living/Skilled Nursing Facility Assessment Tool <input type="checkbox"/> <i>Level I:</i> Pt. requires minimal assistance w/ADL's; is ambulatory or semi-dependent (may use cane or walker but remains independent w/ambulation). <input type="checkbox"/> <i>Level II:</i> Pt. requires moderate assistance w/ADL's & ambulation (uses a wheelchair & requires assistance to bear weight). <input type="checkbox"/> <i>Level III:</i> Pt. requires extensive assistance w/ADL's & ambulation (cannot bear weight/cannot ambulate).
--	--

Patient Age: _____ Height: _____ Weight: _____

Schedule with Provider prior to procedure if:

- Patient is under 21 or over 80 years of age. If under 18, a legal guardian must accompany them to appointment.
- Patient is on Coumadin
- Patient requires an interpreter

If any of the following are answered yes, follow instructions as given:

- Y N**
- Is weight more than 350 lbs? If yes, schedule at hospital.
 - Is patient diabetic? If yes, schedule an AM appointment. Advise patient to check with PCP for changes in medication prior to procedure.
 - Has this patient had the **same** procedure at DHS or other GI clinic within the last 2 years? If yes, give chart to MD to review.
 - Does patient have allergies to eggs or soy products? If yes, document on first comment line of the appt (these patients will be given conscious sedation).
 - Is the patient currently breastfeeding? If yes, mother needs to pump and store enough milk for 12 hours after the procedure.
 - Transportation arranged? If Shuttle, Para Transit, or Cab please schedule in the AM _____
 - Transportation arranged? Driver/Companion must not leave the premises _____

If any of the following are answered yes, let the patient know that a nurse will call him/her, and forward this record to the nurse for further evaluation:

- Y N**
- Does patient have a history of endocarditis or artificial heart valve?
 - Does patient have a pacemaker/defibrillator? If yes, cardiologist name _____
 - Does patient have a history of kidney problems?
 - Does patient have other serious medical problems for which he/she is currently being treated?
 - Unable to transfer from wheelchair to bed (If confined to bed, schedule at hospital.)
 - Is patient on home oxygen?
 - Is the patient in a Nursing Home or Assisted Living Facility?
 If yes, which facility? _____ Phone #: _____
 Contact person? _____
 Who will be accompanying patient? _____
 Can patient sign own consent? Y N If no, who? _____
 Facility needs to send records and current list of meds with staff member who accompanies patient.
 Determine level of care from Assisted Living/SNF Assessment Tool (above). Level: _____
 Level I = OK to schedule • Level II = Requires Nursing Assessment prior to procedure • Level III = Schedule in hospital

Remind patient to call their insurance company and find out what their coverage amount is for the procedure.

THIS INFORMATION WAS OBTAINED FROM: _____

PERSON COMPLETING FORM: _____

Nurse Evaluation, if applicable:	
<input type="checkbox"/> Pacemaker/Defibrillator:	Cardiologist: _____
<input type="checkbox"/> Heart condition:	Taking medication(s): _____
<input type="checkbox"/> Kidney problem:	Currently on dialysis: (Days) S M T W Th F S
<input type="checkbox"/> Assisted Living	
Other Concerns/Comments: _____	
Nurse Signature: _____	Date: _____

Patient ID DHS MD

RMD: _____

Procedure: _____ Date: _____

Indication: _____