Dr. Desh B Sharma, MD
Board Certified Gastroenterology & Hepatology

Direct Colonoscopy/EGD Form

Patient Name: _____ DOB: [/ /]

Patient Phone Number: (_____)_____-_____

Pharmacy Information: (_____)_____-_____

Referring Physician: _____

Have you ever had a colonoscopy? _____

If yes, when and by who? _____

Patient current weight: _____lbs.

Do you require the use of oxygen or a defibrillator? _____

Are you currently taking Aspirin? _____

Have you had a Stroke/TIA? (If yes, when? _____

Are you currently on any blood thinners? (If yes, how long have they been on medication)

_____

Is patient currently having any of the symptoms above;

[ ] Rectal Bleeding [ ] Abdominal Pain [ ] Current Anemia [ ] Significant Weight loss

[ ] Change in Bowel Habits [ ] Chronic Kidney disease or Hx of Renal Failure

List of current medications including dosage & how often:

* *

* *

* *

* *

Drug Allergies: _____

Procedure Code (CPT) *45378 COLON * 43235 EGD *43239 EGD W/BX*45380 COLON W/BX

Diagnosis (ICD-10) * Z12.11 Screening Colonoscopy

Pre-Screen Call taken by: _____ Date: (/ /)

Approved by Physician: _____ Date: (/ /)

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