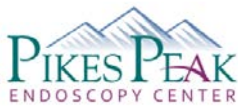


Procedure Financial Disclosure

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

Pikes Peak Endoscopy Center | GACS Gastroenterology Associates of Colorado Springs | Briargate Endoscopy Center

FINANCIAL POLICY AND PATIENT AGREEMENT

IMPORTANT – PLEASE READ

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.

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.

CANCELLATION POLICY: 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 in the appropriate amount of time the below fees will be applied to your account

- Office visits MUST be cancelled/rescheduled no later than **24 hours prior to your appointment; a $25.00 charge will be assessed if this does not occur**.
- Procedures (Colonoscopy/EGD) MUST be cancelled/rescheduled no later than **48 hours prior to your scheduled procedure; a $75.00 charge will be assessed if this does not occur.**

UNINSURED PATIENTS: Payment for services is **due in full** at the time of service or payment arrangements need to be made with our billing department **prior** to the service. For your convenience, we accept VISA, MasterCard, cash, checks and money orders.

INSURED PATIENTS: 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). Please be aware that although we participate with most insurance companies, **it is your responsibility to make sure we are a participating provider with your plan.** 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. **You will be responsible for any remaining balance on your account once your insurance has processed our claim.**

Since your insurance policy is an agreement between you and the insurance carrier, we will not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care.

REFERRALS: 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 it 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.

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 businesses 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.

ADDITIONAL CHARGES:

Missed Clinic Appointments	$25.00
Missed Procedure Appointments	$75.00
Returned Checks	$25.00

OVERPAYMENTS: We will not refund credit balances less than $10.00.

LATE PAYMENTS: Accounts 30 days or more past due will begin accruing finance charges.

COLLECTION AGENCY: We refer all unpaid accounts over 90 days past due to a third party collection agency unless the account has been approved for payment arrangements.

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.

I acknowledge full financial responsibility for services provided to me. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and coinsurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center, and/or Briargate Endoscopy Center.

_________________________	_________________________	______________
Patient Signature	Witness Signature	Date

BRIARGATE ENDOSCOPY CENTER

GACS Gastroenterology Associates of Colorado Springs

PIKES PEAK ENDOSCOPY CENTER

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), or any other Blood Thinners.** You may need to stop these medications a week prior to your procedure.

- **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:**
    a. 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.

    b. Bisacodyl 5mg tablets (any brand i.e. Dulcolax/Fleet/Corretol) – **LAXATIVE NOT STOOL SOFTNER** (available at grocery or drug store over the counter in the laxative section).

    c. Two 64 Oz bottles of G2 Gatorade, Gatorade, Pedialyte or Powerade. **(no red/purple/blue)**

    d. Baby Wipes, Depends, Desitin or A & D ointment (optional)

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.

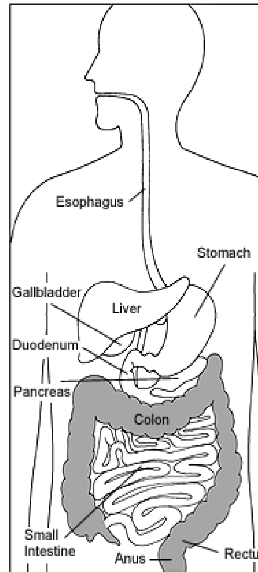
- Continue to drink clear liquids until 2 hours prior to your procedure.

- **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.

FLEXIBLE SIGMOIDOSCOPY

FLEXIBLE SIGMOIDOSCOPY: Flexible Sigmoidoscopy lets the physician look inside the first part of your large intestine, from the lowest part, the rectum, all the way up through the sigmoid colon. This procedure is used to look for early signs of cancer in the sigmoid colon and rectum, and enables the physician to see inflamed tissue, abnormal growths, ulcers, bleeding, and muscle spasms.



For the procedure, you will lie on your left side with your knees bent. 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 tube into your rectum and slowly guide it into your colon. The tube is called a colonoscope. The scope transmits images of the colon, so the physician can carefully examine the lining of the colon. The scope also blows air into your colon, which inflates the colon and helps the physician see better. You may notice some mild cramping and abdominal pressure as the scope is advanced through the lower bowel. These sensations should be completely tolerable and not painful.

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

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. You will not feel any sensation or discomfort when the biopsy is performed. 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 Flexible Sigmoidoscopy. However, such complications are rare.

The procedure can take up to 30 minutes. You will remain in recovery for a period of time until some of the sedative wears off. The findings of your procedure will be discussed with you after the procedure, and written discharge instructions will be given. The sedative given during the procedure can affect your memory of the procedure and discharge. We highly recommend that you have someone with you during this time, so that they can relay the information to you when you are at home and the sedation has worn off.

Preparation: Your colon must be completely empty for the procedure to be thorough and safe. You have been provided instructions you should **read <u>1 WEEK</u>** 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 over the age of 18 to stay during your procedure and drive you home afterward—you will not be allowed to drive because of the sedatives.

CLEAR LIQUID DIET

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!

FOOD GROUP	FOODS ALLOWED	FOODS TO AVOID
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	LUNCH	DINNER
White grape juice	Apple Juice	Lemonade
Clear broth	Clear broth	Clear broth
Jell-O®	Jell-O®	Jell-O®
Tea/Coffee	Tea/Coffee	Tea/Coffee

DIABETIC INSTRUCTIONS

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

MEDICATIONS

- 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

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 # ___.

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

MUST PLACE ID LABEL IN THIS BOX ONLY

NA = Not Applicable

2-18-11
1200029 This Consent is available in Spanish and the content is identical

Timeout Conducted: Date:________ Time:_______ Signature: ____________

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

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 sever 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 patent 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 (List only those MEDS currently being taken)	Route	Dose	Frequency	Reason for Taking	Stop	Comments
1					☐	☐
2					☐	☐
3					☐	☐
4					☐	☐
5					☐	☐
6					☐	☐
7					☐	☐
8					☐	☐
9					☐	☐
10					☐	☐
11					☐	☐
12					☐	☐
13					☐	☐
14					☐	☐

DISCHARGE MEDICATIONS

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

■ Current medications/supplements/herbals list has been reviewed. Recommend continuing as listed, EXCEPT METFORMIN after anesthesia or contrast dye.

☐ Recommend discussing home medications with your primary care physician.

■ If your medications have been held or changed, follow up with your Primary Care Physician.

■ Bring this form to follow up visits

☐ Unable to Obtain Medication History.
Reason: ____________

Data Source: ☐ Patient ☐ Family

☐ Other: ____________

☐ 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____

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

Patient Label

1252454 (12/2009)

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							
Heart Attack				Often tired, fatigued or sleepy during the day			
High Blood Pressure				Has anyone noticed you stop breathing during your sleep			
Do you get short of breath walking 2 flights of stairs				CPAP/BIPAP			
Echo/Stress Test/past yr				**Anesthesia**			
EKG / past yr				Jaw Problems			
Pacemaker / Defibrillator				Motion Sickness			
Lung Disease If yes, who is your Managing Doctor:				Malignant Hyperthermia (you or your family member)			
Cold/Flu last 2 weeks							
Emphysema/COPD				**Infections**			
Asthma				MRSA (Methycillin Resistant Staph Aureus)			
Oxygen Use (flow-route)				VRE (Vancomycin Resistant Enterococcus)			
Chest Xray in past year				Hepatitis			
Diabetes If yes, who is your Managing Doctor:				HIV			
Age Diagnosed				History of/or active Tuberculosis (TB)			
Blood Glucose monitoring			Range ______	Rashes, sores, open wounds			
General Health				**Safety**			
Bleeding Tendencies				History of falling in last 3 months			
Blood Clots / Phlebitis				Unsteady walk or use of cane/walker			
Kidney Failure Problems				**Allergies☐NO, if YES Please complete the following:**			
Liver Problems				Allergies to Medications	Reaction		
Ulcers / Acid Reflux							
Rheumatoid Arthritis							
Polio / Multiple Sclerosis							
Spinal Cord / Head Injury							
Seizure Disorder							
Mental Disability							
Cancer				Food Allergies			
Other Medical Problems:				Latex/Tape			
Social History				Iodine / IV contrast			
Current Smoker				Other:			
# of years smoking / pks Day				**Surgery History**			
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				**PLEASE COMPLETE THE HOME/DISCHARGE MEDICATION PROFILE SHEET**			
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