5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

Capsule Endoscopy

Check Off List
To be completed by *CHECK OUT*

PART 1

Today's date/Date of CONSULT: _____

Patient:_____

Date of Birth:_____

Procedure Date: _____ Time: _____ Scheduled By:_____

PART 2

ONCE STEP ONE IS COMPLETE: Part 2 is to be completed by *CHECK OUT*

Date of Colonoscopy (WITHIN 1 YEAR): _____

Date of Endoscopy (WITHIN 1 YEAR):_____

Does the patient have a pacemaker:_____

Employee Name:_____ Date: _____

PART 3

ONCE STEP TWO IS COMPLETE: Part 3 to be completed by *Referral Coordinator*

Insurance & Pre-cert or referral number:_____

Insurance last verified: _____

Primary Care Doctor:_____

Referral Coordinator: _____ Date: _____

Date Given to Procedure Nurse (Completed): _____

PART 4

ONCE STEP THREE IS COMPLETE: Part 4 to be completed by *Procedure Nurse*

Call Patient 3 days prior to Capsule: Attempt # 1: _____ Attempt #2: _____

Attempt #3: _____

Revised: 1/28/2021