MINISTRY OF HEALTH:

ENDOSCOPY BOOKING FORM

- **MANDATORY FIELDS IN CAPITAL LETTERS**
- **DATES SHOULD BE IN MM/DD/YYYY FORMAT**

Facility Use Only
Hospital Chart #:
Waitlist Start Date:
Booking ID #

HEALTH SERVICE NUMBER:
PATIENT LAST NAME:
FIRST NAME:
Middle Name:
DATE OF BIRTH:
SEX: ☐ M ☐ F ☐ X
PERMANENT ADDRESS: **CITY OR TOWN:** **PROVINCE:** **POSTAL CODE:**
PRIMARY PHONE #
Alternate Phone #
Email Address

SECTION 1: ENDOSCOPY BOOKING INFORMATION		
FACILITY/AREA	**PERFORMING PHYSICIAN**	**Procedure Date/Time/Facility**, if applicable
ADMISSION TYPE ☐ Day Surgery (Endoscopy) ☐ Inpatient ___ days before procedure		Location if in-house urgent:
BOOKING TYPE ☐ New Booking ☐ New Booking – Direct to Procedure (leave First Consult Date blank) *[7_ENDO_DIR]* ☐ Follow-up with Same Physician (leave Referring Physician, Referring Date, and First Consult Date blank) *[9_ENDO_FOL]*		
REFERRING PHYSICIAN	**DATE REFERRAL RECEIVED**	**FIRST CONSULT DATE**
Family Physician	**FIT Positive Result Date**, if applicable	**Last Endoscopy Procedure Date**, if applicable
DIAGNOSIS/INDICATION CODE	**DIAGNOSIS/INDICATION DESCRIPTION** (enter free text if using "other" Dx Code)	

PROCEDURE REQUESTED/PROVINCIAL PROCEDURE CODE/DESCRIPTION	**Estimated Procedure Time**
1. 2.	1. 2.

Available Short Notice (1-5 days)**:** ☐ Yes ☐ No **Target Date** (mandatory for surveillance):

Dates Patient is Unavailable for Endoscopy: From: To: Reason:

From: To: Reason:

Special Equipment/Supplies Needed/Comments ☐ FLUORO

Anesthesia Type ☐ Monitored Anesthesia Care (MAC) ☐ Conscious sedation ☐ Topical ☐ Local ☐ None ☐ General

Alerts/Additional Conditions ☐ CPO ☐ MRSA ☐ XDRO ☐ C. auris ☐ BMI over 40 ☐ IDDM ☐ NIDDM

☐ Latex Allergy ☐ Other Allergies: _____ ☐ Malignant hyperthermia

☐ GLP ☐ Anticoagulants: _____ ☐ Previous reaction to anesthesia

☐ Other please specify:

PHYSICIAN SIGNATURE	**DATE**

SECTION 2: ADDITIONAL PROCEDURE REQUIREMENTS (if applicable)

Endoscope(s) required for procedure:

☐ Regular bronchoscope ☐ Therapeutic bronchoscope ☐ Ultra-slim bronchoscope
☐ Linear EBUS

Radial EBUS probe:

☐ Regular size (17S) ☐ Therapeutic size (20R)

Cryoprobe:

☐ Regular ☐ Therapeutic

Gastrointestinal EUS:

☐ Radial EUS ☐ Linear EUS

Precaution requirements (Respirology procedures only):

☐ Protective environment precautions

☐ Airborne precautions

☐ Other: _____

PHYSICIAN SIGNATURE	**DATE**