

Anesthesia Form
Ulster Endoscopy Care, PLLC
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Please fill out **COMPLETELY** and bring with you the **DAY OF YOUR PROCEDURE**.

- * You **MUST** have a **COMPLETE** and **UPDATED** list of **ALL** current medications along with the dosages, including any supplements you take.
- * You **MUST** write **ALL** allergies along with their reactions.
- * You **MUST** provide us with a **COMPLETE** list of **ALL** Past Medical and Past Surgical History.

Today's Date (DOS): _____

Name: _____

DOB: _____

Primary Care Physician: _____

Height: _____

Weight: _____

Scope: Upper Endoscopy Colonoscopy

Do you smoke? YES _____ NO _____

Do you have a bleeding disorder? YES _____ NO _____

Do you have Sleep Apnea? YES _____ NO _____

Do you use a CPAP machine? YES _____ NO _____

Allergies (including food)

All Current Medications, including over the counter medications and supplements.

Name

Strength

Dose

Past Medical History

Past Surgical History

Patient Responsibilities

All Patients are responsible:

- To bring Insurance Cards with them to each procedure.
- To provide complete and accurate information about their medical history.
- To inform staff of ALL the medications they are taking as well as over-the-counter products, herbal remedies and dietary supplements.
- To inform staff of ALL allergies and reactions.
- To inform staff of ANY changes in Insurance, address or phone number.
- To follow all pre-procedure instructions
- To adhere to the treatment plans recommended by the physician
- For their actions if they should refuse treatment or a procedure or if they do not follow the instructions given to them by the physician or a health care team member.
- To notify the doctor of any change in their condition.
- To keep their appointment. If they anticipate a delay or must cancel, it is their responsibility to notify the facility as soon as possible.
- To arrange for a responsible adult to drive them home and if required by physician, to remain with them for 24 hours. The driver MUST sign discharge instructions prior to the patient being discharged.
- Not to return to work for 24 hours.
- To agree to pay any expenses not covered by their insurance. They will ensure that their financial indebtedness is repaid in a timely manner.
- To tell the facility about any living will, power of attorney, or other advanced directives, and to bring a copy with them.
- For the disposition of their valuables, as this facility does not assume this responsibility.
- To be respectful of healthcare professionals, staff and other patients.

Signature _____

Date _____