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Pre-Anesthesia/Endoscopy Evaluation Request

Please fax to 203-200-2235, + recent H&P, EKG, echo, stress tests, pacemaker interrogations

If information & signed form are not received & patient notified within 3 days of procedure appt, patient may have to be rescheduled

Dear Dr. _____ @ fax _____

Your patient is scheduled for an upcoming Endoscopic Procedure & we appreciate your input.

Patient Name: _____ **DOB:** _____

Procedure: _____ Procedure date: _____ Provider: _____

Indication: _____

Does your patient have any of the following active cardiac conditions?

Yes No Unstable coronary syndrome: severe angina, unstable angina, or MI < 6 mo ago, abnormal stress test or recent cardiac catheterization?

Yes No Decompensated heart failure: NYHA class 4, worsening or new onset CHF, EF <30% or LVAD?

Yes No Severe aortic or mitral stenosis or severe pulmonary HTN (>50mmHg)?

Yes No Significant arrhythmias: high grade or Mobitz 2 AV Block, 3 AV block, symptomatic ventricular arrhythmias, supraventricular arrhythmias with poorly controlled ventricular rate, symptomatic bradycardia, newly recognized ventricular tachycardia, AICD/pacemaker, cardioversion or cardiac ablation?

Yes No Did the patient have a drug eluting stent placed <365 days ago, or a bare metal stent placed <90 days ago.

Is patient on any of the following anticoagulation?

Aggrenox	ASA	Coumadin	Effient	Eliquis	Plavix
Pradaxa	Savaysa	Xarelto	Heparin	Lovenox	Other

Is patient on Insulin or oral DM medication that should be adjusted due to NPO status?

Yes No

RECOMMENDATIONS:

Hold _____ x _____ days prior to procedure

Hold _____ x _____ days prior to procedure

Additional recommendations: _____

Cardiologist/PCP name: _____ Phone: _____

Signature: _____ Date: _____

Please ensure your office has communicated these recommendations to the patient.

