GREAT SOUTHERN SPECIALIST CENTRE

CAPSULE ENDOSCOPY PATIENT INFORMATION

Patient ID (GSSC)		Date / /
Patient Name		Date of birth / /
Address		Suburb
State	Postcode	Phone
Height	Weight	BMI

Have you ever undergone a capsule endoscopy? NO YES

Indication for Capsule Endoscopy GP Referral Specialist Assessment

Do you have any allergies? NO YES

If yes, please provide details

Diabetic	NO YES	NSAID (anti-inflammatories)	NO YES
Pacemaker or defibrillator	NO YES	Difficulty swallowing	NO YES
Warfarin / anti-coagulants	NO YES	Pregnant	NO YES
History of bowel obstruction	NO YES	Chrohns disease with stricture	NO YES
Known small bowel strictures/ narrowing	NO YES		
History of surgery to small or large bowel	NO YES		

OFFICE USE ONLY

Patient taken 1 x Pico-Salax sachet the night before procedure NO YES

Patient informed of complications associated with Endoscopy/capsule failure NO YES

Time of commencement	Time of completion
Signature of Nurse	

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