Garden State
Endoscopy
& Surgery Center
200 Sheffield Street, Suite 101, Mountainside, NJ 07092

Welcome to Garden State Endoscopy & Surgery Center

A staff member from the Garden State Endoscopy Center will contact you the day prior to your scheduled procedure to inform you of the time you must arrive at the center. Please make sure your physician's office has your updated cellphone and home telephone numbers.

If you do not receive a call from center by 1PM the business day prior to your scheduled procedure, you must contact the center directly at 908-241-8900.

This packet contains information on the Garden State Endoscopy and Surgery Center policies on patient rights & responsibilities and advance directives. We have also included copies of the procedure, financial, anesthesia and HIPAA consents for your review. Please read these documents prior to your arrival. These forms will be signed by you electronically on your procedure day.

In order to prepare for your care, we are requesting that you complete the attached patient medication and cardiac history sheet. It is important for us to receive this information *prior to your procedure* to prepare for your care. Please send the completed forms by mail, fax or hand deliver them to our office prior to your procedure date. The information to return the forms is;

Garden State Endoscopy & Surgery Center
200 Sheffield Street
Suite 100
Mountainside, NJ 07092
Fax: 908-241-8933 or 908-241-8799

Please bring your insurance cards and a picture ID with proof of address on your procedure day. It is important that you follow your physicians instructions related to your procedure.

Prompt arrival is important to complete the required registration and admission process. Your anticipated overall length of stay at the Center is approximately three (3) hours. Please arrange your transportation accordingly.

If you have questions in regards to these printed forms, please do not hesitate to contact us at (908)-241-8900 and request to speak with the Nurse Manager.

We appreciate your cooperation and we look forward to providing you excellent care on the day of your procedure.

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Patient's Name: _____ Cellphone: _____

Pharmacy: _____Pharmacy Address_____

Allergies: _____

Please include a list of your current medications including herbal supplements, as well as regular and occasionally used prescription and over the counter drugs

Medication	**Dosage (mg, ml, units)**	**Frequency**	**Date of Last Dose**

PATIENT CARDIOVASCULAR HISTORY

Patient cardiologist/Heart Doctor: _____Phone_____

Have you ever had?	**Date**
_____A Heart attack	_____
_____A Pacemaker or Defibrillator	_____
_____An Echocardiogram/EKG	_____
_____Cardiac Catherization (balloon)	_____
_____Coronary Stent Placement	_____
_____Coronary Bypass Surgery	_____
_____Coronary Valve Placement	_____
_____Stress Test	_____