NEAR EAST UNIVERSITY HOSPITAL

ENDOSCOPY UNIT PATIENT DIAGNOSIS AND FOLLOW-UP FORM (OUTPATIENT)

THE PATIENT'S'

■ Name Surname:	■ Patient ID No:	■ Blood Type:
■ Gender: ☐ Female ☐ Male	■ Department:	■ Room No:
■ Date of Birth: ……/……/……	■ Date of Admission to Service:	■ Time:

■ Social Security Coverage: ☐ Paid Patient ☐ State Referred ☐ İnstitution Discounted ☐ Private Insurance ☐SGK (Social Security Institution)

■ Age: ■ Weight: ■ Height:	■ Marital Status: ☐ Married ☐ Single
■ **Education**:	■Profession:
■ **Communication Barrier:** ☐ No ☐ Yes:_____	■ Interpreter Needed ☐ No ☐ Yes

■Person and Phone Number to Contact if Needed:

■ Place of Arrival at the Department: ☐ Home ☐ ICU (Intensive Care Unit) ☐Emergency Department ☐ Other:_____
■ Method of Arrival at the Department: ☐ Walking ☐ Wheelchair ☐ Stretcher ☐ Other:_____
■ Consciousness State: ☐ Alert ☐ Drowsy/Confused ☐ Unresponsive ☐ Other:_____

■ **Vital Signs**
► Body Temperature:____ºC ► Pulse:____bpm ►Respiratory rate:____bpm (breaths per minute) ►Blood Pressure:_____mmHg ►SpO2 : _____
► Pain ☐ No ☐ Yes ☐ Location-Quality:_____ ☐ Pain score*_____
*** : The patient's pain is assessed using an appropriate scale according to the protocol.**

■ **EARLY DIAGNOSIS/DIAGNOSIS:**

■ **PATIENT HISTORY:**

■ Past Ilnesses: ☐ None ☐ Present (please specify):

■ Past Surgeries: ☐None ☐ Present (Specify Surgery-Date):

■ Was a blood transfusion administered? ☐ No ☐ Yes

■ Known Allergies: ☐ None ☐ Present (please specify):

■ Known Habits: ☐ None ☐ Present (Specify duration and frequency):
☐ Smoking:_____ ☐ Substance: _____ ☐ Alcohol :_____ ☐ Other :_____

■ **Family History - Features:** ☐ None ☐ Present (please specify):

■ **Medications Currently Used:** ☐ **None**

Medication Name	Dose	Method of Administration	Last Administered Time	Medication Name	Dose	Method of Administration	Last Administered Time
1				**4**			
2				**5**			
3				**6**			

SYSTEM REVIEW*

• Cardiovascular ☐No Issues ☐Yes:_____ • Oral/Tongue ☐ No Issues ☐ Yes:_____
• Respiratory ☐No Issues ☐ Yes:_____ • Vision ☐ No Issues ☐ Yes:_____
• Urinary ☐ No Issues ☐ Yes:_____ • Sleep Pattern ☐ No Issues ☐ Yes:_____
• Neurology ☐ No Issues ☐ Yes:_____ • Hearing/Speech ☐ No Issues ☐ Yes:_____
• Skin ☐ No Issues ☐ Yes:_____ • Prostheses ☐ None ☐ Yes:_____
• Gastrointestinal ☐ No Issues ☐Yes:_____ • Other :
• Musculoskeletal System ☐ No Issues ☐ Yes:_____

**** If one or more ıssues are identified during the system review, please inform the doctor.***

Dr._____was informed.

FALL RISK ASSESSMENT

☐ No Risk ☐ High Risk ☐ Age 65 or Older

PRE-PROCEDURE NURSING ACTIVITIES	TIME	NURSE'S NAME AND SIGNATURE
The patient is provided with a procedure-specific informed consent form and their preparation is verified.		
An identification wristband is applied to the patient.		
The patient is informed about the procedure.		
The fasting status before the procedure is checked.		
The arrival of the patient is communicated to the doctor.		
An intravenous line is established according to the doctor's orders.		
Vital signs are recorded.		
Any prostheses, jewelry, or nail polish are removed.		
The patient is dressed in appropriate attire for the procedure.		
The patient's personal belongings are handed over to a family member or secured.		
If the procedure is a colonoscopy, bowel cleansing is checked.		
If the patient is using anticoagulant medication, it is verified whether it has been discontinued.		
If there are any recommended medications before the procedure, it is checked whether they have been taken.		
For a gastroscopy, the mouthpiece is placed.		
The patient is monitored.		
Premedication is administered.		
For gastroscopy or bronchoscopy, Xylocaine spray is applied to the throat.		
The patient is positioned appropriately.		
Patient safety is ensured.		

TREATMENTS DURING THE PROCEDURE

TIME	MEDICATION NAME	ROUTE OF ADMINISTRATION	DOSE	PHYSICIAN'S SIGNATURE	NURSE'S NAME AND SIGNATURE

PROCEDURE

Start Time of Procedure: …….. :…… End Time of Procedure: ……. :……..
Doctor Performing the Procedure:……
Nurse Assisting with the Procedure:……..
Was a biopsy taken? ☐ No ☐ Yes
Was a sample collected for Helicobacter testing? ☐ No ☐ Yes

PRE-PROCEDURE VITAL SIGNS

TIME	TEMPERATURE	PULSE	RESPIRATION	SpO_2	BLOOD PRESSURE	PAIN	NURSE

NURSE OBSERVATIONS AND EVALUATION

☐ Procedure-specific informed consent form was checked.
☐ Patient identification wristband was checked.

TIME	OBSERVATION	NURSE

POST-PROCEDURE VITAL SIGNS

TIME	TEMPERATURE	PULSE	RESPIRATORY	SpO2	BLOOD PRESSURE	PAIN	BLEEDING	NURSE

ACTIONS	TIME	OBSERVATION	NURSE
The patient wil be monitored for nausea and vomiting.			
The side rails of the bed will be raised until the patient is fully awake.			
Mobilization will be provided after the procedure.			
Other:			

PERSON PROVIDING INFORMATION ☐ Patient ☐ Patient's Relative ☐ Other (please specify):_____	**FORM COMPLETED BY NURSE** Date: Time:
Name: **Signature:**	**Name:** **Signature:**