Provider:
Rick A. Shacket BS9262611
3543 N. 7th Street, Phoenix AZ 85014
Office: 602.263.8484 Mobile: 602.920.1023

RICK A SHACKET
DO, MD(H)

Name: _____ DOB: _____ Date: _____

SURGERY PRESCRIPTION SLIP – PAGE 1

Colonoscopy
Diagnosis:
❑ Colon Cancer Screening > Age 45 African American & Age 50 All Others
❑ Gastrointestinal Bleeding (occult or obscure) ❑ Rectal Bleeding
❑ Abdominal Pain with: loss of weight or appetite, perianal disease, ↑ ESR , ↑ CRP
❑ Hx of Colon Cancer ❑ 1st° Family Hx of Colon Cancer
❑ Hx Colon Polyps (adenoma) ❑ 1st° Family Hx Colon Polyps (adenoma)
❑ Change in Bowel Habits – Constipation or Watery Diarrhea
❑ Surveillance of Crohn's Disease ❑ Surveillance of Ulcerative Colitis
Scheduled Colonoscopy on: _____@_____ **Time**: ❑ 30 min ❑ 45 min

EGD ❑ Schedule Same Day as Colonoscopy
Diagnosis:
❑ Heartburn or GERD Despite Appropriate Drug Trial
❑ Heartburn or GERD with Anorexia or Weight Loss
❑ Gastrointestinal Bleeding (occult or obscure) ❑ Persistent Vomiting
❑ Upper Abdominal or Periumbilic Pain ❑ Persistent Nausea
❑ Hx of long-term anti-coagulation, or NSAID Therapy
❑ Anemia - Iron Deficiency or pernicious
❑ Surveillance of Barrett's Esophagus ❑ Surveillance of Adenomatous Gastric Polyps
❑ Familial Adenomatous Polyposis Syndromes ❑ Dysphagia ❑ Odynophagia
Scheduled EGD on: _____@_____ **Time**: ❑ 15 min ❑ 30

Surgery
Diagnosis: ❑ Abscess ❑ Condyloma Anal ❑ Condyloma Genital ❑ Enlarged Papillae
❑ Enlarged Tags ❑ Fissure ❑ Fistula ❑ Hemorrhoids ❑ Prolapse ❑ Stenosis ❑ Spasm
❑ Pilonidal Cyst ❑ Other:
Scheduled Surgical Repair of Above on: _____@ _____
Time: ❑ 15 min ❑ 30 min ❑ 45 min ❑ 60 min

Standard Pre-operative Instructions & Rx Given to Patient: ❑ Yes ❑ No
Standard Post-operative Instructions & Rx Given to Patient: ❑ Yes ❑ No

Signature of Prescribing Physician: _____

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SURGERY PRESCRIPTION SLIP – PAGE 2

Provider Name: Dr. Rick Shacket **Scheduling Office Contact**: Ashley

Benefits Verified: Date: _____ Contact: _____

Colonoscopy Case: _____ **EGD** Case: _____ **Surgery** Case: _____

Ins. Eff. Date: _____ Auth Colon/EGD# _____ Auth Surgery# _____

Medical Records Faxed to: _____ Date: _____

Deductible: $_____ Met: $_____ Coinsurance: $_____

Out of Pocket Max $ _____

❑ Cash Patient: needs a price quoted for facility + Sedation before scheduling. PLEASE, patient has limited means and needs to know the costs before deciding.

❑ Patient is covered by medical/health insurance. Needs to know what his maximum out-of-pocket facility cost can be before deciding to schedule.

Notes: _____

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