



Gastroenterology  
of Greater Orlando

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# Capsule Endoscopy

Date of Consult: \_\_\_\_\_ Scheduled by: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Procedure Date: \_\_\_\_\_ Time: \_\_\_\_\_

Pacemaker: Yes or No

Date of Colonoscopy: \_\_\_\_\_ Date of EGD: \_\_\_\_\_

(WITHIN 1 YEAR):

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