

Name _____

Gastroenterology Procedures

28. Please check any of the following procedures that you perform in your practice:

None of the following apply to my practice. _____ (please initial)

- Sigmoidoscopy
- Upper Endoscopy
- Capsule Endoscopy
- Enteroscopy
- Endoscopic Ultrasound
- Esophageal Banding
- Colonoscopy
- Percutaneous Endoscopic Gastrostomy (PEG) Placement
- Endoscopic Retrograde Cholangiopancreatography (ERCP)
- Endoscopic Mucosal Resection (EMR)
- Radiofrequency Ablation (RFA)
- Stent Placement (esophageal and colonic)
- Balloon Dilatation (esophagus, colon, pancreatico-biliary)
- Sclerotherapy
- Natural Orifice Surgery (NOS)

If yes, please indicate which procedures you perform _____

Other Procedures

- _____
- _____
- _____
- _____