Providence Gastroenterology Open access endoscopy request

LEFT MOUSE CLICK ON INSIDE OF EACH BOX >>> THIS WILL CHECK OR UN-CHECK EACH BOX

Date of request:	Referring Doctor:
Legal Name:	Date of Birth:
Previous Name:	With what doctor: Choose an item.

What procedure do you need? ☐ **Colonoscopy** *{for New Patients, please have Referring doctor send order, thank you}*

☐ **EGD-** Upper Endoscopy *{for EGD please ANSWER last section on page 2}*

Have you had this procedure before? ☐ **Yes** ☐ No … If yes, when:

Why do you need this procedure(s) at this time? ☐ Routine Screening ☐ Other:

Screening Colon; Do you have these symptoms? Rectal Bleed: ☐ **Yes** ☐ No, **Anemia:** ☐ **Yes** ☐ No, **Rectal pain:** ☐ **Yes** ☐ No **IBD:** ☐ **Yes** ☐ No, **Bowel changes:** ☐ **Yes** ☐ No, **Cramping or Abdominal Pain:** ☐ **Yes** ☐ No, **Are you 50 years old:** ☐ **Yes** ☐ No **Any Weight loss:** ☐ **Yes** ☐ No, **Family History of Colon Cancer-1st degree:** ☐ **Yes** {☐ Father ☐ Mother ☐ Sister ☐ Brother} ☐ No

	Yes	No	Comments:
In the last 3 months, have you had Heart attack, stroke, or Congestive heart failure?	☐	☐	(if yes, schedule at hospital)
Do you have an Implanted Cardiac Defibrillator? Or Pacemaker	☐	☐	(if yes, schedule at hospital)
Do you weigh over 350 pounds?	☐	☐	(if yes, schedule at hospital)
Do you use OXYGEN at home?	☐	☐	(if yes, schedule at hospital)
Are you on dialysis?	☐	☐	(if yes, schedule at hospital)
Do you use a wheelchair?	☐	☐	(if yes, schedule at hospital)
Do you use a C-PAP machine?	☐	☐	
Have you or any family member had problems with anesthesia in the past?	☐	☐	
Do you see a heart doctor on a regular basis?	☐	☐	
If yes, Cardiologist please give name & phone under comments >	>	>	
* If yes only, place reason for heart doctor under comments	>	>	
Do you experience chest pain at rest or chest pain unrelieved by Nitroglycerin?	☐	☐	
Do you have a replaced heart valve or heart stent?	☐	☐	
Do you have high blood pressure?	☐	☐	
Do you have diabetes?	☐	☐	
Do you have seizures?	☐	☐	
Do you have an Infectious /Contagious Disease?	☐	☐	
Do you take Antibiotics before dental work?	☐	☐	
For women only; are you pregnant or think you may be?	☐	☐	

SURGERY HISTORY

☐ No history of surgery

☐ Yes / Please list type of surgery and date:

RX & MEDICATION INFORMATION

Are you taking any over the counter or Rx diet pills? ☐ Yes Stop 2 weeks before ☐ No

☐ No known drug allergies

☐ Yes, Known Drug Allergies: Please list:

Click or tap here to enter text.

Name of Medication Dosage	# of capsules/tablets, # X's day	Name of Medication Dosage	# of capsules/tablets, # X's day
Example; Nexium- 40 mg	*1 tab, 1 X a day*		

Certain meds need to be stopped	prior to procedure- see stop days	Contact your prescribing doctor	for approval
Blood thinners-		Effient (presugrel)	< Stop 7 days before
Coumadin (warfarin), Plavix (clopidogrel), Brilinta (ticagrelor)	< Stop 5 days before < Stop 5 days before < Stop 5 days before	Pradaxa (dabigatran), Xarelto (rivaroxaban) Eliquis (apixaban)	< Stop 2 days before < Stop 2 days before < Stop 2 days before

PATIENT PERSONAL INFORMATION	
Last Name:	Primary care Doctor:
First Name:	Cardiac Doctor (if any):
Address line 1:	Sex: Marital Status:
(Apt #/ Unit #):	Working (FT/ PT), Not employed, retired:
City:	Last 4 digits SS #:
State ZIP Code:	Emergency contact name:
Home Phone:	Relationship to you:
Cell Phone:	Emergency contact phone:
e-Mail address:	

INSURANCE	PRIMARY	SECONDARY
Insurance Co. Name:		
Address, (physician bill claims to):		
Group Name (PPO, EPO, HMO):		
Authorization Number (if any):		
Policy, Member #, or Enrollee ID:		
Employer:		
Group Number:		
☐ Self or ☐ subscriber:		
☐ Self or ☐ Subscriber date of birth:		
Subscriber relationship to patient:		

AFFORDABLE CARE ACT INFORMATION	
Race:	Choose an item.
Ethnicity- Hispanic or Not Hispanic:	Choose an item.
Language:	Choose an item.

PHARMACY INFORMATION	
Pharmacy Name:	
Street Address:	
City:	
State ZIP Code:	
Phone:	

For **EGD** insurance companies now require documentation. Please have referring physician fax the diagnosis, treatments, and failures in order to get an insurance approval. Fax information to our office at 248-662-4120. Thank you

	Yes	No	Comments:
Do you have suspected chronic blood loss, or a recent GI bleed?	☐	☐	
Do you have suspected structural disease (obstruction) or have trouble swallowing?	☐	☐	
Do you have any abnormal Diagnostic Imaging? (Lesion, ulcer, narrowing)	☐	☐	
Is this to access injury due to ingestion of caustic substance?	☐	☐	
Do you have documentation of Esophageal varices?	☐	☐	
Do you have upper abdominal pain or systems of dyspepsia (indigestion)?	☐	☐	
Do you have persistent vomiting?	☐	☐	
Do you have pain when swallowing (odynophagia)?	☐	☐	
ANY gastroesophageal reflux (including heartburn, regurgitation, or non-cardiac chest pain?	☐	☐	
Any Barrett's Esophagus noted on previous EGD?	☐	☐	