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: | | | | |
| Click or tap here to enter text. | | | | |
| **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? | |  |  |  |

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| --- |
| surgery history |
| No history of surgery |
| Yes / Please list type of surgery and date: |
|  |
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# rX & MEDICATION INFOrmation

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| --- | --- | --- | --- |
| 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. | | | |
| 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* |  |  |
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| 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: Choose an item. Marital Status: Choose an item. | |
| (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 | | | | |

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| --- | --- | --- | --- |
|  | 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? |  |  |  |