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: |
|  |
|  |

# 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**

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| --- | --- |
| 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? | [ ]  | [ ]  |  |