Providence Gastroenterology Open access endoscopy request

#  (Left click on right side of each box >>> this will check or un-check each box)

|  |  |
| --- | --- |
| Date of request: |  |
| Legal Name: | Date of Birth: |
| Phone: | Referring Doctor: |
| With what Dr  | [ ]  Dr. Laurence E Stawick [ ]  Dr. Mark S. DeVore [ ]  Dr. Julia S. Greer [ ]  Dr. Kha H. Ngo [ ]  Dr. Serge S. Sorser |
| What procedure do you need?[ ]  **Colonoscopy** [ ]  **EGD** |
| Have you had this procedure before?[ ]  Yes [ ]  No … If yes, When: |
| Why do you need this procedure 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**: [ ]  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 or C-PAP machine at home? (Any Oxygen) | [ ]  | [ ]  | (if yes, schedule at hospital) |
| Are you on dialysis? | [ ]  | [ ]  | (if yes, schedule at hospital) |
| Do you use a wheelchair? | [ ]  | [ ]  |  |
|  If yes, ask; can you transfer yourself to a bed without assistance? | [ ]  | [ ]  | (If No, schedule at hospital) |
| 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, 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?  | [ ]  | [ ]  |  |

# rX & MEDICATION INFO

|  |
| --- |
| [ ]  No known allergies |
| [ ]  Yes Allergies: Please list: |
|  |
|  |
| Are you taking any over the counter or Rx diet pills?[ ]  No[ ]  Yes Stop 2 weeks before |
| 1. Name of Medication Dosage
 | 1. # of capsules/tablets, # X’s day
 | 1. Name of Medication Dosage
 | 1. # of capsules/tablets, # X’s day
 |
| 1. *Example; Nexium- 40 mg*
 | 1. *1 tab, 1 X a day*
 | 1. *Example; Lipitor, 10mg,*
 | 1. *1tab, 1 x a day*
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| 1. ***Certain meds need to be stopped prior to procedure- see stop days***
 | 1. ***Contact your prescribing doctor for approval***
 |  |  |
|  |  | 1. ***Blood thinners-***
2. ***Effient (presugrel)***
 | 1. ***< Stop 7 days before***
 |
| 1. ***Coumadin (warfarin),***
2. ***Plavix (clopidogrel),***
3. ***Brilinta (ticagrelor)***
 | 1. ***< Stop 5 days before***
2. ***< Stop 5 days before***
3. ***< Stop 5 days before***
 | 1. ***Pradaxa (dabigatran), Xarelto (rivaroxaban)***
2. ***Eliquis (apixaban)***
 | 1. ***< Stop 2 days before***
2. ***< Stop 2 days before***
3. ***< Stop 2 days before***
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| **any history of surgery** |
| [ ]  No history of surgery |
| [ ]  Yes / Please list type of surgery and date: |
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|  |

**patient personal INFORMATION**

|  |  |
| --- | --- |
| Last Name: | Primary care Doctor: |
| First Name: | Cardiac Doctor (if any): |
| Address line 1: | Sex /Marital status: |
| Address line 2: | Last 4 digits SS #: |
| City: | Emergency contact name: |
| State ZIP Code: | Relationship to you: |
|  | Emergency contact phone: |
|  |
| **insurance INFORMATION** |
| Insurance Company Name: |
| Insurance Policy #: Group number: |
| Who is the subscriber on insurance? |
| Insurance Group number: |
| Subscriber relationship to patient: |
| Insurance billing address: |
|  |
| **GENERAL INFORMATION** |
| Race: |
| Ethnicity- Hispanic or Not Hispanic: |
| Language: |
| **PHARMACY INFORMATION** |
| Name: |
| Address: |
| Phone: |