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

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| --- | --- | --- | --- |
| No known allergies | | | |
| Yes Allergies: Please list: | | | |
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|  | | | |
| 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: | |