Patient Open Access Colonoscopy Request

DATE _______________

Patient Name ____ DOB ___________________

Primary Phone Number ____________________ Secondary Phone Number _______________________

Address ____

City _________________ State ___________ Zip Code ___________ Email _____________________

Insurance name ____________________________ Policy ID # ______________________________

Group ID # ____________________ Primary Subscriber name ________________________________

Referring Physician ___________________ Phone # ___________________ Fax # _________________

Please Circle Yes or No to the following medical questions.

YES – NO Have you ever had a colonoscopy? If yes where and when? _________________________
YES – NO Do you have history of colon polyp or colon cancer?
YES – NO Do you have relatives with colon cancer? If yes, who? ___________ Age at diagnosis? ____
YES – NO Coronary Artery Disease / Angina / Heart attack within the past 1 year?
YES – NO Congestive Heart Failure with hospitalization within the past 6 months?
YES – NO History of Artificial Heart Valve/ Defibrillator/ pacemaker placement?
YES – NO Emphysema, Asthma, Bronchitis, or sleep apnea that is not controlled?
YES – NO Kidney Disease on dialysis?
YES – NO Stroke within the past 1 year?
YES – NO Diabetes that is not controlled?
YES – NO Have you ever had a joint replacement within the last 1 year?
YES – NO Have you ever had a complication with anesthesia?
YES – NO Do you weigh more than 325 pounds?
YES – NO Do you see blood in your bowel movements or black stools?
YES – NO Do you have frequent constipation or diarrhea?
YES – NO Do you take blood thinning medication? (Coumadin, plavix, xarelto, pradaxa, other?)
YES – NO If you have a chronic medical condition, have you been seen by your physician / medical provider within the past 30 days? If yes please fill the information below.

Date of last exam____________________ Primary Care Provider Name__________________________

Please list any active medical problems:

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Please list all medications including vitamins, prescription, and non prescription (include over the counter products) include dosage/ frequency, strength and last taken

Medication Name & Strength	**Dosage**	**Last time taken**

Do you have any allergies to any medication or food? If so please list your reaction below

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How did you hear about us ?

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Once submitted, you will be contacted within three business days by our staff to review your history, verify your insurance, obtain a prescription for the bowel preparation, and receive final instructions for your colonoscopy. This form should never be used for medical emergencies.

Please return this completed form to our office via mail or secure fax.

Mail:
Queen City Gastroenterology
320 Lillington Ave, Suite 101
Charlotte, NC, 28204
Phone: (704) 362- 4403

Fax:
(704) 362- 4405