Screening Colonoscopy

Grand River MEDICAL GROUP

Please use this form when requesting a SCREENING COLONOSCOPY at Grand River Medical Group. Normally, a patient requiring just a screening colonoscopy does NOT require consultation with the gastroenterologist prior to the procedure. If the patient has significant gastrointestinal symptoms, please complete the CONSULT REQUEST FORM. The CONSULT REQUEST FORM applies to all GRMG physicians.

Patient's name: _____ Date of birth: _____

Patient's address: _____

Social Security Number: _____Health insurer (include copy of card): _____

Home Phone # : _____ Cell Ph #: _____ Work Ph #: _____

Referring Physician: _____ Ph # _____ FAX: _____

Before we schedule your patient for a screening colonoscopy, please answer the following questions about your patient. While a consultation is not normally required prior to performing a screening colonoscopy, the answers to these questions MAY prompt the gastroenterologist to request a consultation prior to performing a screening colonoscopy. Thank you.

1. Fecal occult blood test (FOBT) within the last year? _____ NO _____ YES
If "YES", was result "□Positive" or "□Negative"? (check one)

2. Any symptoms or history referable to the colon? _____ NO _____ YES
If yes, please explain:_____

3. Any symptoms or history referable to the upper GI tract? _____ NO _____ YES
(e.g., dysphagia/GERD/epigastric pain/pyrosis)
If yes, please explain:_____

4. Any family history of colon polyps/colon cancer? _____ NO _____ YES
If yes, please indicate which family member/relationship and age of diagnosis (if known):
_____

5. Any significant cardiopulmonary disease? _____ NO _____ YES
If yes, please explain:_____

6 . Any neurological disease? _____ NO _____ YES
If yes, please explain:_____

7. Any anti-platelet agents (e.g., Plavix/Coumadin/aspirin) _____ NO _____ YES
If yes, please record:_____

8. If Yes to #7, can these drugs be held for 5-7 days before procedure? _____ NO _____ YES

9. If Yes to #8, is bridging therapy required? _____ NO _____ YES

If "YES" to #9, do you want □DIM to arrange bridging? OR □Referring provider will prescribe bridging?

10. Has the patient ever had a colonoscopy in the past? _____ NO _____ YES;
If yes, when and where? _____

Please send the completed form to the GI nurse Coordinator at Grand River Medical Group. The fax numbers are 563-589-4046 or 563-557-5560. After your questionnaire has been reviewed, the patient will be contacted by our GI Coordinator to schedule colon cancer screening.