Alabama Medical Group

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GI Patient Referral and Colonoscopy Open Access Form

PATIENT INFORMATION

LAST NAME:	FIRST NAME:		MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:	SEX: F ☐ M ☐	BIRTH DATE:
RACE:	EMAIL ADDRESS:		
STREET ADDRESS:			
CITY:	STATE:	ZIP:	

CHECK SYMPTOM(S)/DIAGNOS(ES)

☐ Acute Pancreatitis ☐ Bile duct stones ☐ Chronic Pancreatitis ☐ Gallstones ☐ Pancreatic Cancer ☐ Pancreatic Disease ☐ Pancreatic Insufficiency ☐ Pancreatiobiliary ☐ **Screening Colonoscopy** (see below for **Open Access** criteria)	☐ Achalasia ☐ Atypical Chest Pain ☐ Barrett's ☐ Dyspepsia ☐ Dysphagia ☐ Esophageal Disease ☐ Esophageal Motility ☐ H. pylori ☐ Reflux ☐ Swallowing Disorder	☐ Crohn's Disease ☐ IBD ☐ Perineal Crohn's Disease ☐ Pouchitis ☐ Ulcerative Colitis	☐ Chronic Abdominal Pain ☐ Chronic Constipation ☐ Chronic Diarrhea ☐ Fecal Incontinence ☐ Functional Disorders ☐ IBS	☐ Constipation ☐ Diarrhea ☐ GI Bleed ☐ GI Malignancies ☐ Hematemesis ☐ Motility Problem ☐ Other: _____

COLONOSCOPY OPEN ACCESS SCHEDULING CRITERIA:

- Colonoscopy is for routine screening, history of polyps/colon cancer, a family history of colon neoplasm or routine colonoscopy for inflammatory bowel disease in remission.
- Patient has NO active symptoms (abdominal pain, a change in bowel habits, etc.)
- Patient does NOT have severe pulmonary or cardiac disease.

Patient meets criteria for an Open Access Colonoscopy: **YES** **NO**

SPECIFIC QUESTIONS TO BE ADDRESSED:

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PRIMARY CARE / REFERRING PHYSICIAN INFORMATION		
PHYSICIANS NAME:		
PRACTICE NAME:		
STREET ADDRESS:	**CITY, STATE, ZIP**	
PHONE:	**FAX:**	**EMAIL ADDRESS:**

INSURANCE POLICY HOLDER INFORMATION (*ENCLOSE COPY OF INSURANCE CARD*)			
POLICY HOLDER'S RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT ☐SPOUSE ☐CHILD ☐OTHER	LAST NAME:		FIRST NAME:
SEX: F ☐ M ☐	BIRTH DATE:		PRIMARY PHONE:
PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE: