



Open Access Screening Colonoscopy Referral Form

This screening program is for *well patients, (no significant gastrointestinal symptoms), between 50 and 75 years, limit of 350 lbs, needing a colonoscopy without the inconvenience of an initial office visit.* (under 50 see below)

Date _____ * *Patient's name must be entered on this form for processing.*

Referring Physician _____ Phone _____ Fax _____

Date _____ Practice _____

Patient Name * _____ DOB _____

* *A demographic sheet may be sent instead of writing in patient information. Open Access does not require records.*

Best Daytime Contact # _____ Cell # _____

Work # _____ Soc Sec # _____

E-Mail _____ *(very important!)*

Address _____

City _____ State _____ Zip _____

Please Fax Insurance Card (front/back) with form. *(If illegible, please fill in below)*

Primary Insurance: _____ Benefits Phone #: (_____) _____

Policy ID#: _____ Group #: _____

Carolina Access Medicaid Appointments: _____ PCP / Group NPI # _____

- **Please check here for family history of colon cancer.** (under age 50)
- Once this form is received, we will contact your patient, obtain pre-procedure insurance benefits, proceed scheduling this appointment.
- This form will be returned to PCP with procedure date contingent upon patient approval.

Endoscopy Location Preference: *(please circle)*

Charlotte • Uptown Area

Pineville • Ballantyne Area

Monroe • Union Co. Area

Matthews • Mint Hill Area

Charlotte • University Area

Huntersville • Lake Norman Area

Concord • Kannapolis Area

Physician Requested _____ Questions? Please call Open Access Dept. (704) 372-7974

CDHA Procedure Confirmation:

Procedure Date: _____ Procedure Time: _____

Procedure Location: _____