Texas Health Care

Colon & Rectal Surgery
Britton R. West, M.D.
Glen D. Hooker, M.D.
Eduardo D. Castillo, M.D.
Lori L. Gordon, M.D.

www.txcolonrectal.com
1420 Eighth Ave., Suite 103
Fort Worth, Texas 76104
Tel: (817) 924-9002
Fax: (817) 924-9960

REQUEST FOR FOLLOW-UP COLONOSCOPY

Dear Patient:

Please fill out the attached paperwork and mail all forms back to our office, along with a copy of the front and back of your insurance card(s). Once the forms are received in our office, Crissy or Shirley will call you to schedule your procedure.

We will contact your insurance company. If for any reason there is a procedure deposit that is due, someone from this office will contact you. Deposits are due one week prior to your procedure.

When scheduling your colonoscopy, please make sure that you check your calendar in advance prior to scheduling. Please make sure that you will have transportation home for the date that the procedure is scheduled. It is very difficult for our scheduler to change your procedure date once it has been scheduled with the hospital or other facility.

Please note the following:

- Dr. West's procedure days are Mondays, Wednesdays and Fridays.
- Dr. Castillo's procedure days are Tuesdays, Thursdays and Fridays.
- Dr. Gordon's procedure days are Mondays, Tuesdays and Thursdays.
- Dr. Hooker's procedure days are Tuesdays, Wednesdays and Fridays.

Your procedure will be scheduled at one of the following facilities, depending on the physician's schedule, your insurance, and the date that you choose:

Baylor All Saints Medical Center, 1400 8th Ave., Fort Worth, TX 76104	817-926-2544
Harris Methodist Hospital, 1301 Pennsylvania Ave., Fort Worth, TX 76104	817-250-2000
Plaza Day Surgery, 909 Ninth Ave., Fort Worth, TX 76104	817-336-6060
Fort Worth Endoscopy Center, 900 W. Magnolia Ave., Ft. Worth, TX 76104	817-332-6500
Southwest F. W. Endoscopy Center, 6445 Harris Pkwy., Suite 150, Ft Worth, TX	817-423-2888
Forest Park Medical Center, 5400 Clearfork Main St., Ft. Worth, TX 76109	682-703-5129

Facility Fee: There will be a separate charge from the facility. The facility will contact you prior to your procedure. If a co-pay is due at the time on the service, you will be notified at the time of the call.

Pathology Fee: If biopsies are taken during your procedure, a pathology fee will be incurred. If there is a balance after your insurance has paid, he may receive a bill for these services.

Anesthesia Fee: Your physician may elect to provide you with an anesthetic administered by an anesthesiologist or a nurse anesthetist. If so, you will be given a short-acting drug which will provide you with a deep sleep and then allow you to wake up quickly after your procedure. If you have not met your deductible, you may be sent a bill for anesthesia services.

If you have any questions or concerns, please do not hesitate to call our office at 817-924-9002.

KEEP THIS SHEET FOR YOUR RECORDS; THERE IS NO NEED TO RETURN IT TO US.

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Your Information

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Home Phone: _____ Cell Phone/Alternate Phone: _____

Record of Disclosures

In general, the HIPAA privacy rule gives patients the right to request on uses and his closures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- ☐ Okay to call home telephone number.
  - ☐ Leave message with doctor's name and callback number only on home voicemail.
  - ☐ Okay to leave a message with detailed information on home voicemail.
- ☐ Okay to call work telephone number: _____
  - ☐ Leave message with doctor's name and callback number only on work voicemail.
  - ☐ Okay to leave a message with detailed information on work voicemail.
- ☐ When unable to contact me by phone, a written communciation may be sent to my home.
- ☐ Other: _____

Health care providers must keep records of PHI disclosures. Information provided on test results, progress notes, or patient communication in question will be documented.

Release of Patient Information

I consent and authorize the release of my results to the following persons:

	NORMAL RESULTS	ABNORMAL RESULTS
Myself	☐	☐
Voice Mail: _____	☐	☐
My Spouse: _____	☐	☐
My Child(ren): _____	☐	☐
My Parent(s): _____	☐	☐
Other: _____	☐	☐

Patient Signature: _____ Date: _____

PLEASE COMPLETE THIS SHEET AND THE FOLLOWING MEDICAL HISTORY SHEET, AND MAIL BACK TO US ALONG WITH A COPY (FRONT AND BACK) OF YOUR INSURANCE CARD(S) IF POSSIBLE.

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MEDICAL HISTORY

Patient's name: _____ **Problem or Reason for Visit**: _____

Current medications (incl. Aspirin, insulin, inhalers, eye drops, supplements); you may attach an additional sheet if necessary.

	Medication	Dose	How often?		Medication	Dose	How often?
1.	_____	_____	_____	5.	_____	_____	_____
2.	_____	_____	_____	6.	_____	_____	_____
3.	_____	_____	_____	7.	_____	_____	_____
4.	_____	_____	_____	8.	_____	_____	_____

Allergies to Medication (please also state type of reaction); Check here if no allergies: ☐

1. _____ 2. _____ 3. _____ 4. _____

Medical History (please check if you have, or have had, any of the following):

☐ High blood pressure
☐ High cholesterol
☐ Heart attack
☐ Other heart disease
Specify: _____
☐ Asthma as an adult
☐ Emphysema
☐ Diabetes
☐ Stroke
☐ Blood clots
☐ Cancer
State body location: _____
☐ Liver failure
☐ Kidney failure
☐ Ulcer disease
☐ Hepatitis
☐ HIV or AIDS
☐ Other medical conditions: _____
_____
_____

Smoking: Current ☐ Former ☐ None ☐
Packages per day ____; Years ____
Alcohol use: Current ☐ Former ☐ None ☐
Drinks per week ____; Years ____
Caffeine: Current ☐ None ☐
Family history of any of these (and state who):
☐ Colorectal cancer: _____
☐ Colorectal polyps: _____
☐ Ulcerative colitis/Crohn's: _____
☐ Other diseases: _____

Surgeries (list type of surgery and approximate year):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Symptoms Review (check beside symptoms you have regularly; if box is not checked, it is assumed you do not have symptom):

Constitutional:
☐ Chills
☐ Fever
☐ Malaise (feel unwell)
☐ Weight loss

Head and Neck:
☐ Double vision
☐ Ear infections
☐ Eye pain
☐ Nasal congestion
☐ Sinus infections
☐ Sore throat

Respiratory:
☐ Shortness of breath
☐ Frequent cough
☐ Pain with deep breath
☐ Wheezing

Cardiac:
☐ Chest pain
☐ Swelling in legs (edema)
☐ Palpitations

Gastrointestinal:
☐ Abdominal pain
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Trouble swallowing
☐ Heartburn
☐ Vomiting blood
☐ Blood in stool
☐ Loss of appetite
☐ Black-colored stools
☐ Nausea
☐ Reflux of food/acid
☐ Vomiting

Genitourinary:
☐ Painful urination
☐ Blood in urine
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention

Reproductive (female):
☐ Breast lumps
☐ Breast pain
☐ Vaginal discharge

Metabolic/Endocrine:
☐ Cold intolerance
☐ Excessive thirst
☐ Heat intolerance

Neurologic:
☐ Dizziness
☐ Headache
☐ Numbness
☐ Tremors
☐ Spinning sensation

Psychiatric:
☐ Anxiety
☐ Depression
☐ Increased stress
☐ Prev. psychiatric care

Skin:
☐ Contact allergy
☐ Hives
☐ Pruritus (itching)
☐ Rash

Musculoskeletal:
☐ Back pain
☐ Myalgia (muscle pains)
☐ Joint pain

Hematologic/Lymphatic:
☐ Easy bleeding
☐ Easy bruising
☐ Swollen lymph nodes

Immunologic:
☐ Asthma
☐ Chemicals at wkplace
☐ Food allergies
☐ Immunosupression
☐ Seasonal allergies

Pharmacy and Location: _____ Pharmacy Number: _____

Patient Signature: _____ Date: _____