Sarah Bush Lincoln
Gastroenterology

FIN: ____________________ **(For Office Use Only)**

Name (Please print) First: ______________________ Last: ______________________

Address: ____

City: ____________________ State: ________ Zip Code: ______________

Phone Number: (_____) ______________ Date of Birth: ______________
xx / xx / xxxx

Primary Care Provider Name First: ______________________ Last: ______________________

Do you have any of the following symptoms that have been chronic within the last 6 months: (please check the appropriate box)

- ☐ Diarrhea
- ☐ Constipation
- ☐ Weight Loss
- ☐ Bloating
- ☐ Rectal bleeding
- ☐ Black or tarry stools
- ☐ Change in bowel habits

Do you have any family history of colon cancer: (please check the appropriate box) ☐ Yes ☐ No

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, did you have any polyps? ☐ Yes ☐ No

Have you ever been seen by a gastroenterologist? ☐ Yes ☐ No

If yes, please list the doctor's name(s):

____

____

I consent to participate in this voluntary health screening. I understand that it is my responsibility to follow up on any abnormal results or concerns with my primary care physician or provider.

______________________________ ____________ ____________
Patient Signature Date Time

______________________________ ____________ ____________
Witness Signature Date Time

For Office Use Only
Test mnemonic: Occult Blood Stool
Test location: Colo-rectal Screening Clinic
Ordering Provider: Alexis Ayonote

COLO-RECTAL CANCER SCREENING