

Colonoscopy Patient Navigator Program – Patient Intake Form

Navigator _____

First Name: _____ **Last name:** _____ **MRN#** _____

Sex: <input type="radio"/> Male <input type="radio"/> Female	Race: <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Asian/Pacific Islander <input type="radio"/> American Indian/Alaskan native <input type="radio"/> Unknown	Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	DOB: ____/____/____ Country of Origin: _____ Primary Language: _____
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Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **E-mail:** _____

Referral Information

Referral appt date: ____________ Insurance: _____
 Referring facility/doctor: _____ Is referring doctor a PCP? Yes No
 Indication for colonoscopy: Screening Diagnostic Surveillance
 PAT clearance date: ____________ Cleared: Yes No
 If not cleared, reason: Medical Financial Other No Show

Patient History

Smoker: Yes No If No, date quit: ____________
 Family cancer history: _____
 Last colonoscopy date: ____________ No prior colonoscopy
 If prior polyps, Type: _____ Size: _____

Colonoscopy Information

Colonoscopy date: ____________ Endoscopist: _____ Completed: Yes No
 If not, reason: _____ Colonoscopy results: _____

Polyps: <input type="checkbox"/> Yes <input type="checkbox"/> No Types: Polyp 1: _____ Polyp 2: _____ Polyp 3: _____ Polyp 4: _____ Polyp 5: _____ Polyp 6: _____	Sizes: Polyp 1: _____ Polyp 2: _____ Polyp 3: _____ Polyp 4: _____ Polyp 5: _____ Polyp 6: _____
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Cancer: Yes No Cancer Stage: 0 I II III IV V
 Surgery required: Yes No Surgery date: ____________ Expired: Yes No
 Next colonoscopy recommended: ____________ Follow up needed: Yes No Follow up date: ____________

Navigator Activities

Date: ____________	<input type="checkbox"/> Phone call <input type="checkbox"/> In person <input type="checkbox"/> Other	Description: _____
Date: ____________	<input type="checkbox"/> Phone call <input type="checkbox"/> In person <input type="checkbox"/> Other	Description: _____
Date: ____________	<input type="checkbox"/> Phone call <input type="checkbox"/> In person <input type="checkbox"/> Other	Description: _____
Date: ____________	<input type="checkbox"/> Phone call <input type="checkbox"/> In person <input type="checkbox"/> Other	Description: _____