Sarah Bush Lincoln
Fayette County Hospital

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

Name (Please print) First: _____ Last: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

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: SBL Fayette County Hospital
Ordering Provider: Sharon Draper, APRN

COLO-RECTAL CANCER SCREENING