# Direct Referral for Colonoscopy Procedure

**Patient Information or Label:**

Name:

DOB:

Pt Height/Weight: Phone:

Every patient directly referred for colonoscopy must receive a prescription for bowel preparation and thorough bowel preparation instructions from the referring physician. Patients not fit for direct referral (See Section II, below) should be referred to a GI specialist for assessment prior to colonoscopy.

Date of Referral: / /

### Reason for procedure:

O Asymptomatic person age 50 years and older

O Asymptomatic person at high risk

O First degree relative with colon cancer

O Personal history of adenomatous polyps (Most recent exam: / / )

**Medical History:** Circle “**yes**” or “**no**” for each item below. *If “****yes****” is selected for any of the items below, the patient may not be a good candidate for direct referral. Consult with a GI specialist.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Is the patient…?** |  |  | Notes: |
| Age 70 or older? | Yes | No |  |
| Under treatment for heart failure or valve-related concerns? | Yes | No |  |
| Under treatment for kidney disease? | Yes | No |  |
| Under treatment for emphysema? | Yes | No |  |
| On anti-platelet or anticoagulation medication (including over-the-counter medication such as aspirin) and cannot safely stop it for one week? | Yes | No |  |
| Under active treatment for a recent episode of diverticulitis? | Yes | No |  |
| Pregnant or possibly pregnant? | Yes | No |  |
| **Does the patient…?** |  |  | Notes: |
| Have heme (+) stool, hematochezia, or iron deficiency anemia? | Yes | No |  |
| Have a pacemaker or automatic implantable cardioverter defibrillator? | Yes | No |  |
| Have Inflammatory Bowel Disease (Ulcerative Colitis or Crohn’s Disease)? | Yes | No |  |
| Have a history of severe cardiac/pulmonary/renal/hepatic disease requiring oxygen supplementation or causing high risk for sedation/anesthesia-related complications? | Yes | No |  |
| Have a history of endocarditis, rheumatic fever, or intravascular prosthesis? | Yes | No |  |
| Have a history of difficult, incomplete, or poorly prepped colonoscopy? | Yes | No |  |
| Have a history of difficulty with previous sedation/anesthesia? | Yes | No |  |
| Have a history of sleep apnea? | Yes | No |  |
| Have a BMI of >45? | Yes | No |  |

**Is the patient on medication for diabetes?** □ Yes □ No **if yes:** Request an A.M. appointment: Advise patient on how much and

when to take their oral diabetes medications, insulin to avoid hypoglycemia while on clear liquid bowel preparation and during procedure.

**Is the patient allergic to LATEX?** □ Yes □ No

**Does the patient have anaphylactic latex reaction?** □ Yes □ No

**Is the patient allergic to any MEDICATION?** □ Yes □ No List:

**Please list all medications and OTC supplements below (attach additional sheets as necessary):**

Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose: Medication: Dose:

**Please note any other relevant medical/surgical history:**

Abdominal/pelvic surgery

Abdominal/pelvic radiation

Other, please list:

### Assessment: This patient is a good candidate for a direct referral for colonoscopy. □YES □ NO

Physician Signature: Physician Name (Print):