



# GASTROENTEROLOGY ASSOCIATES, INC. WEST RIVER ENDOSCOPY

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## COLONOSCOPY REFERRAL FORM

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Date of Birth Social Security #

\_\_\_\_\_ Address City State Zip

\_\_\_\_\_ Home Phone Cell Phone Work Phone

\_\_\_\_\_ Insurance Name ID #

\_\_\_\_\_ Referring Physician Physician's telephone #

### INDICATION

#### Screening:

- Colon cancer screening
- Personal history of colon cancer or polyps
- Family history of colon cancer or polyps

#### Diagnostic:

- Iron deficiency anemia (may be combined with an upper endoscopy)
- OB+ (may be combined with an upper endoscopy)
- Rectal bleeding

#### Past/Current History

- Sleep apnea
- Severe COPD
- Severe CHF
- MI < 6 months / unstable angina
- Renal insufficiency
- Prosthetic heart valve
- Congenital systemic-pulmonary shunt
- History of endocarditis
- Other \_\_\_\_\_

#### Medications:

- Coumadin
- Plavix
- Persantine
- Other \_\_\_\_\_

#### Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would patient prefer an office consultation prior to the day of the test?

Yes

No