GASTROENTEROLOGY ASSOCIATES, INC.
WEST RIVER ENDOSCOPY

Alyn L. Adrain, M.D.
Valley Dreisbach, M.D.
Tian Gao, M.D.
Neil R. Greenspan, M.D.
Daniel Greenwald, M.D.
Brett D. Kalmowitz, M.D.
David Schreiber, M.D.
Jeremy Spector, M.D.
Samir A. Shah, M.D.

Rhode Island
44 West River Street, Providence
333 School Street, Pawtucket
One Commerce Street, Lincoln
905 Pontiac Avenue, Cranston

Tel: 401.274.4800 / 508.784.2184
Fax: 401.454.0410

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