OPEN ACCESS ENDOSCOPY CRITERIA

You are requesting a procedural service which does not constitute the assumption of care and/or consultative services. If these services are requested, please refer your patients for a Gastroenterology consultation. The referring provider is also responsible for prescribing the preparation for colonoscopy.

PATIENT NAME

DOB

TELEPHONE #

REFERRING PHYSICIAN

TELEPHONE #

Please refer to the **Exclusion Criteria** section first. If any apply – STOP! DO NOT complete or fax form. The Patient MUST BE SEEN BY ONE OF OUR PHYSICIANS. Please call (609) 924-1422 to schedule this appointment.

**EXCLUSION CRITERIA:**
- Age greater than 70
- Congestive Heart Failure
- MI or chest pain within the last 12 months
- COPD (FEV ;less than 1.25, home oxygen use)
- Coagulopathy (INR greater than 2) or Bleeding Disorder
- Platelet Count less than 75,000

If no exclusions – FAX THE COMPLETED FORM TO (609) 924-7473.
OUR OFFICE WILL CONTACT YOUR PATIENT TO SCHEDULE THE APPOINTMENT.

Indication for colonoscopy:
- Colorectal Cancer Screening
  - Average risk (no family history of CRCa, age 50 or greater)
  - Personal history of colon polyps
  - Family history of colon cancer
  - Other ________________________________
Patient Name: ___________________ Address: ___________________ Telephone: ___________

Referring Physician: ________________________________________________________________

HISTORY:
History of Sleep Apnea: Yes____ No ____
Past Medical/Surgical History: ______________________________________________________

Allergies:
☐ No known allergies
☐ Egg/Soy
☐ Other (please explain): _____________________________________________________________

Current Medications (including vitamins/herbals): ______________________________________

PHYSICAL EXAM:
WGT: ______ HGT: ______ B/P: ______ P: ______ BMI: ______

HEENT: ___Normal ___Abnormal Findings: __________________________
LUNGS: ___Normal ___Abnormal Findings: ____________________________
CARDIAC: ___Normal ___Abnormal Findings: ____________________________
ABDOMEN: ___Normal ___Abnormal Findings: ____________________________
EXTREM: ___Normal ___Abnormal Findings: ____________________________
NEURO: ___Normal ___Abnormal Findings: ____________________________
OTHER: ___Normal ___Abnormal Findings: ____________________________
LAB/XRAY: ___Normal ___Abnormal Findings: ____________________________

IMPRESSION: _____________________________________________________________________

PLAN: COLONOSCOPY
PRE-OP DIAGNOSIS: Colorectal Cancer Screening (Z12.11)

PC Physician SIGNATURE: ___________________ DATE: __________ TIME: __________
H+P reviewed. MD has examined the patient; no changes noted.

GASTROENTEROLOGIST SIGNATURE: ___________________ DATE: __________ TIME: __________

DATE OF SERVICE: __________________________________________________________________

Signature ___________________ Date/Time __________ Signature ___________________ Date/Time __________