PRINCETON GASTROENTEROLOGY ASSOCIATES, P.A.

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 ;ess 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 _____**

PRINCETON ENDOSCOPY CENTER
OPEN ACCESS ENDOSCOPY
HISTORY AND PHYSICAL

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)**

PCPhysician SIGNATURE: _____ **DATE:** _____**TIME:**_____

__H+P reviewed. MD has examined the patient; no changes noted.

Signature_____ Date/Time_____

__H+P reviewed. MD has examined the patient; the following changes are noted: _____

Signature_____ Date/Time_____

GASTROENTEROLOGIST SIGNATURE: _____ **DATE:** _____ **TIME:**_____

DATE OF SERVICE: _____