#

# Gastroenterology Department

Dear Provider,

Please complete this form and fax along with your patient’s current history/physical records, medication list, and any recent lab work to **312.413.3798**. Once we receive this information, we will contact your patient to schedule their procedure.

**Patient Information:**

Patient name:

DOB:

MRN:

Phone number:

Insurance Provider:

Insurance Contact Information:

**Provider Information:**

Ordering Provider:

Provider’s phone number:

Provider’s fax number:

**To be completed by referring Provider**

1. Indication (select one below)
	1. Age 50 or greater first colonoscopy or > 10 years from previous
	2. Under 50 with significant family history of colon cancer in a first-degree relative or multiple second-degree relatives at a young age
	3. Surveillance of prior cancer or adenoma > 1cm or multiple adenoma 3 year or more since last colonoscopy
	4. Surveillance of prior small adenoma > 5 years
	5. Other (explain)

1. Has the patient been seen in clinic in the last 30 days? (Y/N)
2. Does the patient speak English? (Y/N)
	1. If not, what is their primary language?
3. Is the patient decisional? (Y/N)
	1. If not, is there a POA or guardian listed in the chart? (Y/N)
	2. Does the POA/Guardian agree to the procedure? (Y/N)
4. Is the patient on Coumadin? (Y/N)
	1. Can it be held? (Y/N)
	2. Is bridging necessary (Y/N)
5. Is the patient on Plavix, Aggrenox, Pradaxa, Xarelto, or other blood thinner? (Y/N)
	1. If yes, can it be held? (Y/N)
	2. If so, how long?
6. Does the patient have sleep apnea, class 4 airway, severe COPD, home oxygen requirements, or another respiratory issue to warrant Anesthesia service for consultation/sedation? (Y/N)
7. Has the patient had a recent MI or CVA in the last 6 months, labile blood pressures or new complaints of chest pain/shortness of breath that need evaluation? (Y/N)
	1. If yes, explain:
8. Does the patient have a pacemaker or defibrillator? (Y/N)
9. Is the patient on hemodialysis? (Y/N)
	1. If yes, what days?
10. Does the patient take chronic narcotic pain medications, benzodiazepine or other sedatives, or history of drug/alcohol abuse? (Y/N)
	1. If yes, explain:

Thank you for choosing University of Illinois Hospital and Health Sciences System for your care.

Questions: 312.413.7676
Fax: 312.413.3798

Your signature below acknowledges your order for a screening colonoscopy for this patient.

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Provider Signature Date