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