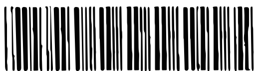

Patient Admin. Forms 1500005

UVA ENDOSCOPY

OPEN ACCESS ENDOSCOPY REFERRAL FORM

Colonoscopy • EGD (Upper Endoscopy) **Telephone:** 434.924.9999 **Fax:** 434.924.8144

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:	SEX: F M / BIRTH DATE:
RACE:	STREET ADDRESS:	
CITY:	STATE:	ZIP:

Interpreter Needed? YES NO LANGUAGE:______________________________

INDICATIONS

COLONOSCOPY

- ☐ Average Risk Colon Cancer Screening*
- ☐ Colon Cancer Surveillance (personal history of polyps)*
- ☐ Family History of Colon Cancer Details:____________________
- ☐ GI Bleeding
- ☐ Unexplained Iron Deficiency Anemia
- ☐ Chronic Diarrhea >3 weeks
- ☐ Unexplained Weight Loss
- ☐ IBD (Ulcerative Colitis or Crohn's Disease)
- ☐ Positive Hemoccult, FIT, COLOGUARD, CT Colonography Date:__________
- ☐ Other Indication: ____

EGD (Upper Endoscopy)

- ☐ Persistent GERD symptoms
- ☐ R/O or F/U Barrett's
- ☐ Dysphagia
- ☐ Persistent dyspepsia
- ☐ Nausea / vomiting
- ☐ Unexplained weight loss
- ☐ Unexplained iron deficiency
- ☐ GI Bleeding

* Date and location of last colonoscopy:______________________________(Please include a copy of report and pathology)

RISK FACTORS

PLEASE CHECK ANY BELOW (to help us determine location/ sedation type or if clinic visit is needed)

- ☐ Age >80 years
- ☐ BMI >40
- ☐ COPD with FEV1 <1.0
- ☐ Sleep Apnea
- ☐ Anemia with HCT <18%
- ☐ Pregnancy
- ☐ Unable to provide consent
- ☐ Defibrillator
- ☐ MI/Angina/severe CHF w/in 6 mo
- ☐ Coagulopathy, hereditary hemorrhagic disorder
- ☐ Treatment with any anticoagulant/antiplatelets (excluding aspirin)**

** ☐ The referring provider will manage discontinuation or bridging of the anticoagulant.

PREP

PLEASE LET US KNOW WHICH PREP YOU HAVE ORDERED:

- ☐ **GoLYTELY** 4 Liters PEG 3350-KCL-NABCB-NACL-NASULF 236 G PO SOLR
- ☐ **Suprep** 355ml NA SULFATE-K SULFATE-MG SULF 17.5-3.13-1.6 GM/177ML PO SOLN
- ☐ **GoLYTELY Extended** 8Liters PEG 3350-KCL-NABCB-NACL-NASULF 236 G PO SOLR [for patients with past poor prep and/or chronic constipation]
- ☐ **UVA ENDOSCOPY TO ORDER PREP**, must include pharmacy details:

Pharmacy Name:____________________ City:____________________ Street:____________________

Prep instructions in English and Spanish can be found online:
https://uvahealth.com/services/colon-cancer-care/colonoscopy

REFERRING PHYSICIAN

PHYSICIANS NAME:		
PRACTICE NAME:		
STREET ADDRESS:		CITY, STATE, ZIP:
PHONE:	FAX:	REFFERING CONTACT NAME:

INSURANCE

POLICY HOLDER INFORMATION (*PLEASE ENCLOSE COPY OF INSURANCE CARD*)

POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF PARENT SPOUSE CHILD	LAST NAME:	FIRST NAME:
SEX: F M	BIRTH DATE:	PRIMARY PHONE:

PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:

TO SCHEDULE: FAX the completed form along with copy of latest office note including allergies, med list, height, weight, past medical and surgical history, and physical exam to **434.924.8144**. We will contact the patient. **QUESTIONS:** 434.924.9999

NOTE: Some indications and risk factors may require patient to be triaged to our Digestive Health Clinic.
Check this box if you request for patient to be seen in clinic first

Outside Facility - 1400000

As of November, 2018