UI Health | UIC

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 your procedure.

PATIENT INFORMATION:

PATIENT NAME:

DOB:

MRN:

PHONE NUMBER:

INSURANCE PROVIDER:

INSURANCE CONTACT INFORMATION:

PROVIDER'S INFORMATION:

ORDERING PROVIDER:

PROVIDER'S PHONE NUMBER

PROVIDER'S FAX NUMBER

PATIENT NAME:_____**DOB**_____

To be completed by referring Provider

1. **Indication (select one below)**
    a. **Age 45 or greater first colonoscopy > 10 years from previous**
    b. **Under 45 years of age with significant family history of colon cancer in a first degree relative or multiple second-degree relatives at a young age**
    c. **Surveillance of prior cancer or adenoma >1 cm or multiple adenoma 3 year or more since last colonoscopy**
    d. **Surveillance of prior small adenoma > 5 years**
    e. **Other (explain)**

2. **Has the patient been seen in the clinic in the last 30 days? (Y/N)**

3. **Does the patient speak English? (Y/N)**
    a. **If not, what is their primary language?**

4. **Is the patient decisional? (Y/N)**
    a. **Does the POA/Guardian agree to the procedure? (Y/N)**
    b. **Is the POA or guardian listed in the chart? (Y/N)**
    c. **If not, please provide name and phone number:_____**

5. **Is the patient on Coumadin? (Y/N)**
    a. **Can it be held? (Y/N)**
    b. **Is bridging necessary? (Y/N)**

6. **Is the patient on Plavix, Aggrenox, Pradaxa, Xarelto or other blood thinner? (Y/N)**
    a. **If yes, can it be held? (Y/N)**
    b. **If so, how long?**

7. **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)**

8. **Has the patient had a recent MI or CVA in the last 6 months, labile blood pressures or new complaints of chest pain/shortness or breath that need evaluation? (Y/N)**

   If yes, explain:

9. **Does the patient have a pacemaker or defibrillator? (Y/N)**

10. **Is the patient on hemodialysis? (Y/N**

    If yes, what days?

11. **Does the patient take chronic narcotic pain medications, benzodiazepine or other sedatives, or history of drug/alcohol abuse? (Y/N)**

    If yes, explain:

Thank you for choosing University of Illinois and Health Sciences System for your care. If there are questions, please call (312) 413-7676.

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

Provider Signature **Date**