Carnegie Hill Endoscopy
An Affiliate of Beth Israel Medical Center

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# Direct Referral For Colonoscopy Procedure

Every patient directly referred for colonoscopy must receive a prescription for bowel preparation and through bowel preparation instructions from the referring physician. Patients not fit for direct referral (See Section II, below) should be referred to a GI specialist for assessment prior to colonoscopy.

**Reason for procedure:**

- Asymptomatic person age 50 years and older
- Asymptomatic person at high risk
- First degree relative with colon cancer
- Personal history of adenomatous polyps (Most recent exam: _____ / _____ / _____ )

**Patient Information:**
Name: _____
DOB: _____ / _____ / _____
Height: _____ Weight: _____
Telephone Number: _____
Mobile Number: _____
Mailing Address: _____
_____
Email Address: _____
Insurance Provider: _____
Policy ID #: _____

**Medical History:** Circle "**yes**" or "**no**" for each item below. If "**yes**" is selected for any of the items below, the patient may not be a good candidate for direct referral. Consult with a GI Specialist.

| **Is the patient…** | | | **Notes:** |
|---|---|---|---|
| Age 75 or orlder? | Yes | No | |
| Under treatment for heart failure or valve-related concerns? | Yes | No | |
| Under treatment for emphysema? | Yes | No | |
| On anti-platelet or anticoagulation medication (including over-the-counter medication such as aspirin) and cannot safely stop for one week? | Yes | No | |
| Under active treatment for a recent episode of diverticulitis? | Yes | No | |
| Pregnant or possibly pregnant? | Yes | No | |
| On medications for diabetes? **If yes**, Schedule A.M. appointment. | Yes | No | |
| Allergic to any MEDICATION? **If yes,** please list. | Yes | No | |
| Allergic to Latex? | Yes | No | |
| Allergic to anything not previously mentioned? **If yes**, please list. | Yes | No | |
| **Does the patient…** | | | Notes: |
| Have iron deficiency anemia? | Yes | No | |
| Have a pacemaker or automatic implantable cardioverter defibrillator? | Yes | No | |
| Have Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease)? | Yes | No | |
| Have a history of severe cardiac/pulmonary/renal/hepactic disease requiring oxygen supplementation or causing high risk for sedation/anesthesia-related complications? | Yes | No | |
| Have a history of endocarditis, rheumatic fever, or intravasculart prosthesis? | Yes | No | |
| Have a history of difficult, incomplete, or poorly prepped colonscopy? | Yes | No | |
| Have a history of difficulty with previous sedation/anesthesia? | Yes | No | |
| Have a history of sleep apnea? | Yes | No | |

**Primary Care Provider Information:**
Name: _____
Telephone Number: _____
Address: _____
_____

**Appointment Information:**
Doctor Scheduled:_____
Date: _____ Time: _____
Scheduled by: _____
☐ Visit necessary prior to date listed above

**How did you hear about us?**
☐Physician referral ☐Patient referral ☐Newspaper ☐Internet Search ☐ Other: _____

NYC Health

New York Citywide Colon Cancer Control Coalition