



OUR CARE IS ALL ABOUT YOU!

OPEN ACCESS ENDOSCOPY CRITERIA

You are requesting a procedural service which does not constitute the assumption of care and/or consultative services. If these services are requested please refer your patients for a Gastroenterology consultation.

The referring provider is also responsible for prescribing the preparation for colonoscopy.

PATIENT NAME

DOB

TELEPHONE #

REFERRING PHYSICIAN

TELEPHONE#

Please refer to *Exclusion Criteria*** section *first*. If any apply- STOP! DO NOT complete and fax form. Patient MUST BE SEEN BY ONE OF OUR PHYSICIANS. Please call (609) 924-1422 to schedule this appointment.**

****Exclusion Criteria:**

- Age greater than 70
- Congestive heart failure
- MI or chest pain within last 12 months
- COPD (FEV less than 1.25, home oxygen use)
- Coagulopathy (INR greater than 2) or Bleeding disorder
- Platelet count less 75,000

**If no exclusions—FAX THE COMPLETED FORM TO (609) 924-7473.
OUR OFFICE WILL CONTACT YOUR PATIENT TO SCHEDULE THE APPOINTMENT.**

Indication for colonoscopy:

Colorectal cancer screening

- Average risk (no family history, age greater than 50)
- Personal history of colon polyps
- Family history of colon cancer
- Other _____