APPALACHIAN REGIONAL HEALTHCARE SYSTEM
Appalachian Gastroenterology

870 State Farm Road, Suite 102, Boone, North Carolina 28607| Telephone 828-264-0029| Fax 828-265-3305

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Colon Cancer Screening Program Referral Form

Instructions/Checklist

- Please review and check the appropriate **Indications** and **Exclusion Criteria** below.
- Fax this form, a copy of the patient's current insurance card AND demographic information to our office at 828-265-3305.
- Our Referral Coordinator will contact the patient and fax a confirmation including appointment details to your office.

Patient's Name _____ DOB _____

Gender: M F Wt. (lbs.) _____ Ht. _____ Daytime Phone Number _____

Referring Provider _____ Phone Number _____

Indications: If patient meets one of these criteria, they will be scheduled with an RN, prior to the procedure.

❑ Preventive Screening Colonoscopy – Patient is asymptomatic (no GI symptoms either past or present), over the age of 50, has no personal or family history of GI disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

❑ Surveillance Colonoscopy – Patient has past GI symptoms, polyps, GI disease or anemia OR patient is asymptomatic (no GI symptoms either past or present), has a personal history of GI disease, personal and/or family history of colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g., every 2-5 years).

Date of last exam if known _____

Exclusion from Direct-Access Colon Cancer Screening Program: If patient meets one of these criteria, they will be scheduled with Dr. Trate or our PA/FNP, prior to the procedure.

❑ >85 years old, particularly with co-morbidities
❑ Daily alcohol or drug use (heroin/cocaine)
❑ Cardiac defibrillator
❑ Asthma, COPD or other breathing problems
❑ Cardiac pacemaker
❑ Multiple and/or unstable co-morbidities
❑ On anticoagulation: Coumadin, Lovenox or Heparin
❑ Prosthetic heart valve, history of endocarditis or rheumatic heart disease, systemic pulmonary shunt or synthetic vascular graft, or other indications requiring prophylactic antibiotics prior to endoscopic procedure
❑ Seizure disorder
❑ Pregnancy
❑ Swallowing difficulties
❑ Renal failure/dialysis
❑ Uncontrolled diabetes

Please do not use this form for GI Diagnostic Consultations. Thank you for your referral!

Referring Provider Signature	Date: Time:
Referring Provider Name *(Please Print)*	

Effective Date: Not Set
Revised Date: 03/29/2018
Form Number: 11355

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