SCREENING COLONOSCOPY REFERRAL
PATIENT INFORMATION

Name of Patient_____ Date of Birth_____

Telephone: Home: _____ Cell: _____

Referring Physician_____ Fax #_____

Exclusionary Criteria for Colon Clinic

- Symptoms: Abdominal pain, rectal bleeding, change in BM, Wt. loss, etc.
- Blood thinners (Coumadin, Warfarin, Plavix, Ticlopidine, Pradaxa, etc)
- Any patient younger than 45 years without family history of colon cancer/colon polyps (recommend early screening for patients with: ONE 1st degree relative diagnosed with CRC or Advanced Adenoma at any age. Begin screening at age 40 or 10 years before the youngest affected relative.
- Over 75
- BMI > 50
- Recent Diverticulitis (Screening 6-8 weeks post flare refer to Provider clinic)
- History of ANY TYPE bleeding disorders
- Cirrhosis of the liver
- Unstable Coronary Artery Disease
- Severe COPD
- Internal defibrillator
- Dialysis
- Inflammatory bowel disease: Crohn's, Ulcerative colitis
- Diagnosis of Invasive Adenocarcinoma/Colon Cancer within the last year
- Positive Genetic Testing for **1.** Lynch Syndrome **2.** Familial Adenomatous Polyposis Syndrome (FAP)
- Needing language interpreter and/or sign language interpreter

***If patient has exclusionary criteria for colon clinic refer directly to Provider Clinic**

Referring Physician Name _____
Faxed by: _____
Send copy of insurance and most recent office visit to include medication list

Fax this sheet to (540)332-5723
Phone (540)332-5526