



Blue card for DHMC Use Only

ENDOSCOPY REQUEST

(Please either fax or mail)

Requesting MD/provider: _____

(Please Print)

Patient: _____ DOB _____

Office phone number: _____

DHMC-MR# _____ Phone #: _____

Office fax number: _____

Address: _____

COLONOSCOPY

___ Screening: 50 yrs or older average age risk

- No personal or family hx polyps or cancer
- Must be 10 yrs from last colo, or 4 yrs from last flex sig to meet Medicare and insurance company payment guidelines

Specific Indications:

___ Personal hx polyps: what type? _____ last exam _____

___ Personal hx of colorectal cancer: last exam _____

___ Personal hx of inflammatory bowel disease

___ colon cancer screening ___ for diagnosis

___ Family hx of colorectal cancer or polyps (*Circle one*)

Relation _____ age at time of diagnosis _____

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___ Fecal occult blood positive

___ Iron deficiency anemia

If colonoscopy does not reveal bleeding source (melena or IDA), do you want upper endoscopy (EGD) done at same time? ___yes ___no

___ Hematochezia (rectal bleeding)

___ Evaluation of abnormality on barium enema

describe: _____

ESOPHAGOGASTRODUODENOSCOPY

___ Upper abdominal distress/dyspepsia

___ 50 yrs or older ___ failure after test & treat

___ Dysphagia/odynophagia (*Circle one*)

___ Gastrointestinal bleeding/iron deficiency anemia (upper GI source suspected)

___ Barretts esophagus surveillance
date of last EGD: _____

___ Follow-up of gastric or esophageal ulcers

___ Reflux sx (persistent/recurrent) despite treatment

___ Evaluate abnormality on UGI x-ray
describe: _____

FLEXIBLE SIGMOIDOSCOPY

___ screening ___ Suspected rectal disease when colonoscopy not indicated

ALL OTHER INDICATIONS/PROCEDURES REQUIRE PHONE CALL OR E-MAIL TO GI CONSULT MD (CALL 603-650-5261 FOR FURTHER INFORMATION)

*****IMPORTANT: PLEASE COMPLETE BELOW*****

<u>YES</u>	<u>NO</u>	<u>PAST/CURRENT MEDICAL HISTORY</u>
()	()	Prosthetic heart valve
()	()	History of endocarditis
()	()	Recent MI (< 3months/unstable angina)
()	()	Insulin-dependent diabetes mellitus
()	()	History of abdominal aortic aneurism. <i>If present, what size? _____</i>
()	()	History of problems with conscious sedation/anesthesia <i>If yes, nature of problem _____</i>
()	()	Prior colonoscopy or sigmoidoscopy (<i>Circle one</i>) <i>Please include report if a NON-DHMC study</i> Date: _____

<u>YES</u> *	<u>NO</u>	<u>MEDICATIONS</u>
()	()	Coumadin (if yes, indication _____)
()	()	Anti-platelet drugs
()	()	Insulin
()	()	Recent chemotherapy

*** If yes, referring physician should manage anticoagulants or insulin BEFORE this procedure. Call 603-650-2805 to discuss management.**