CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

817 Commercial Street Leavenworth, WA 98826
Endoscopy/Colonoscopy Department p: 509-470-2042 fax: 509-548-1411

Endoscopy/Colonoscopy Department

Fax Cover Sheet

Date:

TO: **Fax #:**

ATTN:

FROM: CM Colonoscopy Department

PAGES (including cover): 3

CONTENTS: Endoscopy/Colonoscopy Referral

☒ Please respond !!

REFERRAL ORDER MISSING ITEMS

☒ **Endoscopy Referral Form – PCP to complete form on next page and sign at the bottom.**
☒ **Referral for the specific type of procedure** – EGD, Colonoscopy, Both, or flex sigmoidoscopy
☒ **Face sheet:** mailing address, insurance & phone number
☒ **H&P within 30 days of referral**: with medical/surgical history and updated medication list
☒ **Last EGD/colonoscopy report**
☒ **Prior authorization from insurance** – !! Please fax a copy of the PA !!

****Please do NOT advise your pt to call our facility**. The coordinator will contact your patient when this referral is completed.

Thank you for your interest in our Endoscopy/Colonoscopy services.

Services may be denied at the discretion of our provider/facility due to a variety of safety/facility reasons.

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Cascade Medical Center Endoscopy/Colonoscopy Referral

Patient Name: _____DOB: _____

Code Status		**Procedure**	
	Full Code		Upper Endoscopy (EGD)
	DNR		Colonoscopy
	Do not Intubate		EGD AND Colonoscopy
	See POLST/Advanced Directive		Flexible Sigmoidoscopy

Indication		**ASA Classification**		
	Screening		ASA I	**A normal healthy patient.** No smoking, no or minimal drinking
	Family History		ASA II	**A patient with mild systemic disease.** Smoker, more than minimal drinking, pregnancy, obesity, well controlled diabetes, mild lung disease.
	Guaiac/Cologuard Positive		ASA III	**A patient with severe systemic disease, not incapacitating**
	H/O Polyp Cancer When: What type of Polyp: Size:	Comments:		
	Other:			

Relevant Medical History (please provide relevant information and/or consider preliminary evaluation for any affirmative responses) Please comment or have specific notes about medical history in H&P if the answer is YES:

Medical History:	**YES**	**NO**	**Comment:**
Significant active disease (Cardiac, Pulmonary, Renal, Hepatic, GI, Sleep Apnea)			
Diabetes Mellitus Comment if YES. Meds? Insulin? Stable?			
Anticoagulation? Comment if YES			Most Recent INR:
History of infective endocarditis, prosthetic valve, complex congenital heart disease or surgery?			
History of significant alcohol, narcotic use, or recreational drug use?			
History of cardiac defibrillator implant or pacemaker?			
Prior anesthesia adverse reaction?			
History of constipation? (standard vs extended bowel prep)			
Date Last Colonoscopy/EGD (please attach previous record)			

Referring Provider: _____**Facility:** _____ **Phone:** _____

Provider signature: _____ **Date:** _____