

# Colorectal Screening Referral Form

Date of Referral: \_\_\_ / \_\_\_ / \_\_\_

<b>Screening Colonoscopy</b>	<b>Asymptomatic</b>
	<input type="checkbox"/> Average Risk Age 50 and older <input type="checkbox"/> Increased Risk <input type="checkbox"/> Personal History of: <input type="checkbox"/> Adenomatous Polyps AND/OR <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Family History (1 <sup>st</sup> degree relative) of: <input type="checkbox"/> Adenomatous Polyps AND/OR <input type="checkbox"/> Colorectal Cancer
<b>Diagnostic Colonoscopy</b>	<b>Positive CRC Screening Test – within the past 3 months</b>
	<input type="checkbox"/> FOBT <input type="checkbox"/> FIT <input type="checkbox"/> Asymptomatic PRIOR to screening <input type="checkbox"/> FlexSig <input type="checkbox"/> Barium Enema
	<b>Symptomatic – check all that apply</b>
	<input type="checkbox"/> Hematochezia <input type="checkbox"/> Melena <input type="checkbox"/> Anemia <input type="checkbox"/> Unexplained Fatigue <input type="checkbox"/> Bloody Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Unintentional Weight Loss >10% of ind. body weight <input type="checkbox"/> Abdominal Distention <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Recent (within last year) & Persistent Abdominal Pain <input type="checkbox"/> Recent & Persistent Change in Bowel Habits (check applicable) <input type="checkbox"/> Diarrhea <input type="checkbox"/> Narrow stools <input type="checkbox"/> Constipation <input type="checkbox"/> Feeling of unemptied bowel
	<b>Previous Procedures with an abnormal finding</b>
	<input type="checkbox"/> Digital Rectal Exam <input type="checkbox"/> CAT Scan <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI <input type="checkbox"/> CEA Blood Test What abnormal finding? _____

Patient Information or Label
Name: _____
DOB: _____
Address: _____ _____
Phone: _____
Insurance: _____
Policy #: _____

Date of Onset for all symptoms checked	
DATE	SYMPTOM
___ / ___ / ___	_____
___ / ___ / ___	_____
___ / ___ / ___	_____
___ / ___ / ___	_____
___ / ___ / ___	_____

## MEDICAL HISTORY - Please answer YES or NO to all questions

Cardiac Disease <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Atrial Fibrillation _____ CABG _____ CAD _____ Heart Failure _____ MI / CVA	Taking ASPIRIN or NSAIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking COUMADIN? <input type="checkbox"/> Yes <input type="checkbox"/> No Taking PLAVIX? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Diabetes                       Yes     No    - if YES, Insulin Dependent?     Yes     No  
 Pulmonary Disease         Yes     No  
 Renal/Kidney Disease       Yes     No  
 Latex Allergy                 Yes     No  
 Hemophilia/Other blood disorders     Yes     No    EXPLAIN if YES: \_\_\_\_\_

Medications	Dose
_____	_____
_____	_____
_____	_____

**ASSESSMENT:** This patient is a good candidate for a direct referral for colonoscopy     Yes     No

Physician Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Patient Navigator: \_\_\_\_\_