Lahey CLINIC

ENDOSCOPY REFERRAL ORDER

FAX TO: 781-744-5479

ORDERING PHYSICIAN: _____

phone number: _____ email or fax number: _____

TIME FRAME: ❑ Urgent ❑ 2 weeks ❑ 3 months ❑ Other: _____

PATIENT INFORMATION

Patient Name: _____ DOB _____

Best phone number: _____

Primary care physician (if different from ordering MD): _____

Other (primary language, caretaker name, etc.): _____

PROCEDURE

❑ **COLONOSCOPY**

REASON: (Note to physician: NOT recommended for abdominal pain or constipation.)

❑ Screening ❑ Hem occult positive stool ❑ Rectal Bleeding ❑ Iron Deficiency

❑ History Polyp ❑ History Colon Cancer ❑ Family History Colon Cancer (first degree relative)

❑ Other _____

❑ **EGD**

REASON:

❑ Iron Deficiency ❑ GERD/Barretts ❑ Dysphagia

❑ Abdominal Pain ❑ Follow up Ulcer ❑ Other _____

❑ **FLEXIBLE SIGMOIDOSCOPY**

REASON:

❑ Screening ❑ Rectal Bleeding ❑ Other _____

PATIENT MEDICAL INFORMATION

❑ MD consult prior to procedure

ALLERGIES: ❑ NKDA ❑ Latex ❑ Other: _____

PRIOR ENDOSCOPY HISTORY: ❑ None

(test) _____ (date) _____ (location) _____

MEDICATION MANAGEMENT

❑ **Anticoagulants**: _____

NOTE TO Referring Provider: Instruct patient to discontinue all anticoagulants (including aspirin and NSAIDs) 5 days prior to scheduled procedure and restart as directed by physician.
Prescribe bridging medications if needed.

❑ Patient will NOT be able to interrupt anticoagulation therapy. (Screening will be done however polyps will not be removed.)

❑ **Insulin**

NOTE TO Referring Provider: Instruct patient to adjust insulin to accommodate pre-procedure fasting.

❑ Diabetic ❑ History of endocarditis (prophylaxis antibiotics will be given).

❑ Sedation concerns: _____

❑ Other: _____

Please fax (781-744-5479) with referral request:

Recent/relevant: • History & Physical • Lab • Pathology • Operative reports

For any questions, concerns, or to get additional blank forms please call: 781-744-8690 (M-F 8:00 – 4:30).

DATE & TIME _____ Provider Signature _____