Kentucky Colon Cancer Screening Program
Colonoscopy Referral Form

Patient Name: _____ _____ _____ __ __ __/ __ __/ __ __ __
(Last) (First) (MI) Social Security Number

Visit Date (or most recent visit) _____/____/_____ Month/ Day /Year	Date of Birth: _____/____/_____ Month/ Day /Year	Gender: Male ☐ Female ☐

Referring Provider Name: _____ Office #: _____

Address: _____ Fax #: _____

Increased Risk Indication for Colonoscopy

☐ Recent Positive FIT finding
☐ Personal hx of hyperplastic or adenomatous polyps
☐ Personal hx of colorectal cancer
Last Colonoscopy Date: _____
☐ Immediate Family hx of colorectal cancer
Relation _____ age at dx_____
Relation _____ age at dx_____
☐ Family history of Familial Adenomatous Polyposis (FAP)
☐ Family history of NonPolyposis Colorectal Cancer (HNPCC)
☐ Personal hx of Crohn's Disease
☐ Personal hx of Ulcerative Colitis
☐ Rectal Bleeding not connected to hemorrhoids
☐ Unexplained weight loss of 10% or more
☐ Other Significant GI symptoms – describe
_____

_____

Other Relevant Medical History (may require special consideration/instruction for colonoscopy)

☐ Pacemaker/Defibrillator ☐ Recent MI < 3 months
☐ Unstable Angina ☐ Prosthetic Heart Valve
☐ Hypertension ☐ Diabetes
☐ COPD ☐ Sleep Apnea ☐ Home O2 dependent
☐ Joint Replacement in past year
☐ Hx of Abdominal Aortic Aneurysm
☐ Hx of problems with conscious sedation
☐ Recent Chemotherapy

Is patient on Medications that require suspension or altered schedule before or during procedure?

☐ Anticoagulation drug ☐Antiplatelet drug
☐ Oral Diabetes drug ☐ Injectable Diabetes drug

☐ Allergies (please list) _____

_____

I have determined that this patient is:

☐ Clinically appropriate for outpatient colonoscopy and has been instructed regarding any changes in medication prior to colonoscopy

☐ Requires further evaluation by another health care provider (list provider type) _____

☐ Patient is not clinically appropriate for outpatient colonoscopy (reason) _____

Referring MD/APRN/PA Name (Print) _____

Referring MD/APRN/PA Signature _____Date _____

Instructions

This form is to be used by health care providers (MD, APRN, PA) in referring patients for colonoscopy through the Kentucky Colon Cancer Screening Program (KCCSP).

Please complete this form to show:

1. Reason(s) for recommending a colonoscopy for this patient.
2. Relevant medical history which may impact whether the patient is clinically appropriate for colonoscopy or require special instruction.
3. Use of medications which may require special instruction on use prior to colonoscopy.
4. Indicate whether you have determined:
    a. The patient is clinically appropriate for outpatient colonoscopy and has been instructed on any needed changes in medication use prior to the procedure.
    b. If the patient requires further evaluation by another health care provider.
    c. If the patient is not clinically appropriate for outpatient colonoscopy.
5. 1 copy of this form is for your records.
6. 1 copy of this form should be given to the patient.
7. 1 copy of this form should be returned to the local patient navigator for the Kentucky Colon Cancer Screening Program.