



FAX COVER

Referral form to Kootenai Clinic Gastroenterology & Endoscopy

Patient Name: _____ Date of Birth: _____

Patient Phone Number(s): _____

Referring Provider: _____ Phone Number: _____

Referring for (please select below options):

- Colonoscopy
 - Routine screening /surveillance
 - Diagnostic
- EGD
- EGD / CSP
- ERCP
- EUS
- ERCP / EUS

Evaluation / Treat: _____

Medical Condition(s) present:

- MI ≤ 6 months
- Cardiac Event ≤ 6 months
- Date of last EKG: _____
- Home O2
- CKD with Cr ≥ 2.0
- Pregnant
- CHF (EF < 40%)
- GSN / CPAP
- BMI ≥ 50
- History of polyps or abnormal scope
- Family history of colon cancer

Medications:

Diabetic medications: Oral Insulin

Anti-Coagulation: _____

- Okay to hold Anti-coagulation per Endoscopy Medication Management Protocol
- Protocol not appropriate for this patient, bridge therapy per recommendations below

Please fax this form and all the available listed below to (208) 625-4596:

- Last pertinent chart note
- Medication list (if not in chart note)
- Relevant, current labs, imaging or pathology
- Prior outside GI evaluations
- Demographics
- Insurance referral (if applicable)

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