KootenaiClinic

1919 Lincoln Way, Suite 416Coeur d'Alene, ID 83814(208) 625-4595 phone (208) 625-4596 fax

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 ONE of the below options – office consult or procedure):

☐ Office Consult
Clinical question to answer: _____

☑ Colonoscopy
- ◯ Routine screening /surveillance
- ◉ Diagnostic

■ EGD / CSP ■ EGD

☐ ERCP ☐ EUS ☐ ERCP / EUS

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:

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

Confidentiality Statement: The information contained in this message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone or fax.