Endoscopy Open Access Referral

Endo Unit Direct Line (915) 521-7843

Referring Provider: _____ Clinic: _____
Provider Cell Phone#* _____ Office Phone#_____
This number will be used to report any critical findings or for physician to physician communication only
Office Contact: _____ Office Fax# _____

Patient Demographics
Name: _____
Phone Number: _____ Alternative Number_____
Date of Birth: _____ Age: _____ Gender: _____
Insurance
Insurance: _____Policy #_____
Note: Most HMO Care Plans Require Prior Authorization to be initiated by PCP Office

CLINICAL INFORMATION

Diagnosis: _____
Note: Please do not state "refer to GI clinic" or "gastro consult" as this would disqualify for Open Access authorization

Procedure: Date of Last Procedure:_____

☐ Colonoscopy ☐ EGD ☐ EGD and Colonoscopy

☐Breath Test ☐Other_____

PRIORITY: ☐URGENT ☐1 WEEK ☐2-4 WEEKS ☐ELECTIVE_____

☐Allergies/Special precautions: _____

☐Diabetes ☐CHF or Hypertension ☐Pulmonary ☐Renal Failure ☐ Sleep Apnea

Drug Medication: ☐On Clopidrogel ☐On Warfarin ☐On NSAIDs

Referring Provider Signature: _____ Date: _____

1. **FAX THIS FORM to (915) 521-2209**
   Attach patient H&P, Current Medication list, any labs and diagnostic testing results
2. **CALL (915) 521-7301 to SCHEDULE and confirm fax**
3. Or instruct patient to take referral form and schedule their own appointment at UMC's Center for Diagnostic & Advanced Endoscopy – 3rd Floor, North Tower (Blue Elevators)

UNIVERSITY MEDICAL CENTER OF EL PASO
DIAGNOSTIC & ADVANCED ENDOSCOPY
3rd Floor North Tower • 4815 Alameda Ave. • El Paso, TX 79905
P: 915)521 7301 F: 915)521 2209
(Rev. 1/16) **umcelpaso.org**

PATIENT IDENTIFICATION LABEL

Checklist/ Guidelines for
Open Access for Screening Colonoscopy

Is patient 50 years or older? _____ (***If no - patient does not qualify for screening colonoscopy, unless there is 1st degree family history of colon cancer.)***

***If yes to any question below patient will need to be referred to GI clinic first.**

YES / NO Coronary Artery Disease/ Angina / Heart Attack
YES / NO Congestive Heart Failure
YES / NO Valvular Heart Disease / Artificial Heart Valve
YES / NO Do you take blood thinning medication (Coumadin, Aspirin, Xarelto, or Plavix)?

If yes, please indicate if able to stop and how many days prior to procedure and when to resume post procedure.

- Patient will need cardiac clearance prior to clinic visit if yes to any of the above questions with any recommendations if needed.

YES / NO Emphysema, COPD, Asthma, or Bronchitis requiring regular medical therapy
YES / NO Sleep Apnea
YES / NO Kidney Disease
YES / NO Stroke
YES / NO Have you ever had a complication with anesthesia?
YES / NO Do you weigh more than 350 pounds?

YES / NO Have you ever had a colonoscopy? If yes when?
_____

- If less than the recommended time frame from previous colonoscopy procedure note, please refer to GI clinic or indicate reason.

***For any questions/concerns please contact UMC Endoscopy Department at (915)521-7843.**