Endoscopy Services

A Department of Rutland Regional Medical Center

1 Albert Cree Drive, Rutland, VT 05701
802.786.1400 | 802.786.1405 fax | www.RRMC.org

REFERRAL FORM

Name: _____ DOB: _____ Age: _____

Address: _____

Preferred Phone: _____ Alternative Phone: _____

Primary Insurance Name: _____ Policy # _____ Group# _____

REQUIRED: PLEASE FAX THE FOLLOWING INFORMATION TO 802.786.1405

❒ Patient Demographics ❒ Medication List ❒ Most Recent Office Note ❒ Previous Endoscopy Reports ❒ Problem List

OPEN ACCESS ENDOSCOPY: ❑ First Available ALL Providers

❑ **First Available (GI):** J. Williams, MD & M. Gleeson, MD, PhD

❑ **First Available (Surgeon):** M. Conway, MD, A. Dudzik, MD, M. Hurtado, MD or B. Jimmo, MD

❑ **Specific Provider:** ❑ M Conway, MD ❑ A Dudzik, MD ❑ M. Gleeson, MD, PhD
❑ M Hurtado, MD ❑ B Jimmo, MD ❑ J Williams, MD

COLONOSCOPY ❑ **EGD** ❑ **COLONOSCOPY/EGD** ❑ **SIGMOIDOSCOPY**

Service Appointment Requested (choose one): ❑ Urgent ❑ Routine

Special Needs: (Wheelchair, transfer assist, etc.) _____

SCREENING COLONOSCOPY:

(Please check all that apply)
____Screening: 50 years or older average age risk
____Screening: High risk (family Hx of CA/polyps)

DIAGNOSTIC COLONSCOPY: *(Please check all that apply)*
____ Personal Hx of polyps: Last exam_____
____ Personal Hx of colorectal cancer: Last exam_____
____ Personal Hx of Inflammatory Bowel Disease
____ Family history of colorectal cancer or polyps (circle one)
____ Fecal occult blood- positive
____ Iron Deficiency Anemia
____ Hematochezia (rectal bleeding)
____ Evaluation of abnormality or barium enema or CT scan

ENDOSCOPY/EGD:

____Gastrointestinal bleeding
____Dysphagia/odynophagia
____Upper abdominal distress/dyspepsia
____Reflux symptoms (persistent/recurrent) despite treatment
____Barrett's Esophagus Surveillance
Date of last EGD:_____
____Follow-up of gastric/esophageal ulcer
____Evaluate abnormality on UGI
____Iron Deficiency Anemia

****Diagnosis/reason for visit:** _____

IMPORTANT: ***MUST BE COMPLETED IN ORDER TO SCHEDULE REQUESTED PROCEDURE WITH APPROPRIATE SEDATION***

Yes	No	PAST/CURRENT MEDICAL HISTORY
❒	❒	Prosthetic heart valve
❒	❒	History of endocarditis
❒	❒	Recent MI (<3 months/unstable angina)
❒	❒	Renal Insufficiency
❒	❒	Hx of CHF
❒	❒	Diabetes Mellitus – Insulin dependent

Yes	No	MEDICATIONS
❒	❒	Antiplatelet drugs (not including Aspirin)
❒	❒	Anticoagulants-Indications: _____
❒	❒	Medication Assisted Treatment (i.e. Suboxone/Methadone)

Referring Provider: _____ Phone #: _____ Fax #_____

Date: _____

Patient Label