Center for Gastroenterology
Specialists in Digestive Health

Direct Access Endoscopy Form
Scheduling Information

Location where procedure to be scheduled: (*Please Circle Location Preference*)

Fort Collins	Greeley	Loveland
Fax Number: (970) 297-6368	(970) 378-1515	(970) 461-6260

Requesting Physician: _____

Date of Request:_____ Patient Name:_____

Patient DOB:_____ Patient Home Phone:_____

Patient (Circle one): Male or Female Patient Work Phone:_____

Patient Address:_____

Insurance Carrier:_____ *Best time to contact patient for assessment & scheduling:*_____

Insurance ID Number:_____

Patient Speaks: English_____ Spanish_____ Other_____

❑ Any GI Physician? or ❑ GI Physician Preference:_____

Procedure Requested:
Please note that if the patient has any indications listed below (under Colonoscopy), they cannot be scheduled for a screening.)

COLON CANCER SCREENING:
(*Please mark all that apply)*

❑ Family History of Colon Polyps or Colon Cancer

❑ Personal History of Colon Polyps or Colon Cancer

❑ Average Risk (Age 50+)

Date of Last Colonoscopy: _____

EGD
Procedure Indications:
(Please Circle)

Abdominal Pain
Iron Deficiency Anemia
GERD
Barrett's
Dyspepsia
Hematemesis
Weight Loss
Other: _____

COLONOSCOPY
Procedure Indications:
(Please Circle)

Abnormal Imaging Study
IBD
Diarrhea
Iron Deficiency Anemia
Hematochezia
Heme + stool
Polyp follow-up
Staging of malignancy–Type:

PHYSICIAN / NURSE TO COMPLETE BELOW

GI Screening Questions

Section I – If you answer yes to any question in section I, the patient will need to have an office Visit at the Center for Gastroenterology.

NO YES Does the patient live in a Nursing Home or Assisted Living?
NO YES Does the patient take Coumadin, Warfarin, Pradaxa or any other blood thinners?

Section II - If you answer yes to any question in section II, the GI Physician(s) have asked to review the DAE form before HSC can schedule your patient.

NO YES Does the patient have Congestive Heart Failure? If no, skip ** next question.
NO YES ** If yes, does the patient become short of breath in their daily activities that limit what they can do?
NO YES Does the patient have problems with their kidneys such as renal failure or are they on dialysis?
NO YES Does the patient have lung problems that require them to be on oxygen consistently (COPD)?

Section III – HSC Internal question for packet information purposes.

NO YES Is the patient Diabetic – insulin dependent? (if yes, please include Diabetic Instructions in their packet)

Please fax this form to the number listed below the LOCATION (see above).