

Please fax form and other documents
To: **TDMH 519-842-2048**

Patient Information (or affix label)

Name: patName	Address: patStreetAddress patAddressLine2
City: patCityAddress	Postal Code: patPostalCode
Home Phone: patHomePhone.default	Alt Phone: patMobilePhone.default
DOB: patBirthdate.yyyymmssdd	Referring Provider:
HCN: patHN patVersionCode	PIN:
Email Address: patEmail	

Referring Physician: currMdName
Phone: currMdPhone.default Fax: currMdFax.default

Pre-Procedure Diagnosis:

Mandatory – History/Medical condition list and current accurate medications are attached or documented electronically in OneChart

Schedule procedure:

Next Available Urgent Within 1 Week Within 2 Weeks Within 1 Month

Endoscopy Procedure Name: Gastroscopy Other:

Colonoscopy (if colonoscopy is selected complete Reason for Colonoscopy section next)

Reason for Colonoscopy (Choose only one reason FD,FIT, SA,CN,OS below):

Screening:

FD - First Degree relative had Colorectal Cancer (First Degree relative includes only biological mother, father, sister, brother, daughter or son. Does not include extended family members – e.g. aunt, grandparents, in-laws (CCO Target = 182 days/26 weeks)

FIT - Abnormal fecal immunochemical test (CCO Target = 56 days/8 weeks)

Surveillance:

SA - Symptomatic or has had an abnormal lab test other than FIT

CN - Surveillance for colorectal neoplasm/polyps **OS** - Other Screening

Preparation:

Bi- Peglyte Peglyte Purg-Odan

Endoscopist's Name:

First available Dr. Barnett Dr. Crosby

Confirmed Procedure Date:

Procedure Time: To be provided 1 day prior to procedure

TDMH Scheduling Office Use Only

Date Procedure Scheduled (yyyy/mm/dd):

Patient available in case of cancellation

Diabetic Blood Thinners Pre Registration Information package sent

Has the patient tested positive for COVID-19 in the past 8 weeks? Yes No

If yes indicate in public comment field, if no schedule PCR test

Schedulers Initials: