Thank you for consulting with the UK HealthCare Endoscopy Center. 
To ensure this order is processed as quickly as possible, please follow the instructions outlined below.
We appreciate your referral and look forward to working with you and your patients.

Order Instructions:
1. Complete all sections of this form. Please note, this form serves as an official order and must be fully completed and signed by the patient's medical provider. Incomplete or illegible forms or forms submitted without an official signature will be returned for completion.
2. Fax page 2 of this form to 859-257-9843 (do not fax page 1). Please include only the patient's last H&P and any lab results taken within the last 30 days.
3. The Endoscopy Center will attempt to contact each patient for scheduling by phone. When the Endoscopy Center is unable to reach a patient, a letter will be sent informing the referring provider.
4. Providers referring self-pay patients will be required to complete a Physician Determination form to determine the urgency of the requested procedure. To obtain a copy of the Physician Determination form, please call (859) 323-0374 or email endosch@uky.edu.
5. If multiple patients are referred at one time, each order must be faxed individually.
6. Procedures will only be scheduled when the Endoscopy Center receives a signed and completed order form from the referring provider.
7. When patients taking nonsteroidal antiinflammatory drugs (NSAIDs), anticoagulants or antiplatelet drugs are referred, the Endoscopy Center expects the Referring Provider to discuss how patients should adjust their medication in preparation for the procedure.

NOTE: If your patient requires immediate endoscopic care, please have the requesting provider call UK-MDs at 800-888-5533 and ask to speak with the gastroenterologist on call.

Locations:
For your convenience, the UK HealthCare Endoscopy Center operates facilities at UK Chandler Hospital and UK Good Samaritan Hospital in Lexington, KY. Patients may be scheduled at either facility depending on availability and patient preference. For information about where your patient's procedure will be performed, please call 859-323-0374.

UK Chandler Hospital
800 Rose Street
Lexington, KY 40536

UK Good Samaritan Hospital
310 South Limestone
Lexington, KY 40508

About UK HealthCare Open Access Endoscopy
UK HealthCare Open Access Endoscopy is available to expedite patient care when Referring Providers feel that the indication for an endoscopic procedure is straightforward. Patients referred through Open Access Endoscopy must be in stable, good health (ASA level I or II) and should not require a thorough evaluation by a gastroenterologist.

At the time of endoscopy, the attending physician in the Division of Digestive Diseases and Nutrition will obtain a brief history and physical of the patient to determine the medical safety of the procedure and to confirm the indication. Patients referred through the UK HealthCare Open Access Endoscopy do not receive a full consultation.

Once the procedure has been performed, a report and interpretation of findings will be mailed to the Referring Provider and available on the UK Physician Portal. Additional reports (such as biopsy and cytology) from specimens obtained during the procedure will be forwarded when available. Patients will also receive a letter stating the findings for pathology.

When referred via Open Access, the Referring Provider remains responsible for the patient's care, interpreting medical treatment, and arranging subsequent referral or treatment. Members of the Division of Digestive Diseases and Nutrition will provide recommendations for follow up and advice when appropriate based on the abbreviated history obtained from the patient and are available for discussion and consultation through UK-MDs at 1-800-888-5533.

Please note, this is page one of a two-page form.
This form can be found online on the UK Physician Portal.
**Patient Information**

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Email

UK MR # (if applicable)

Phone (home) Phone (work) Phone (mobile)

Insurance company ID number

Preauthorization number

Referral number (please include if HMO insurance)

**Referring Provider Information**

Name of practice

Name of ordering provider

Title (MD, DO, APRN, PA)

Phone number

Fax number

Address

City State Zip code

Name of representative completing this form

**Consent**

Competent Adult

Family / Guardian present to sign

Intermittent

Regularly

**NSAI Ds**, Anticoagulants or Antiplatelet Drugs

“Nonsteroidal antiinflammatory drugs

Types:

Iron or Multi-Vitamin with Iron

Yes

No (Patient must be off iron supplements at least 10 days prior to colonoscopy)

**Types:**

Why Taken:

**Please indicate below the procedure(s) to be done. Please check all that apply.**

**Colonoscopy for colorectal cancer screening / surveillance in HIGH RISK individual**

- q None
- q Date ____________________
- q Location ____________________
- q Parent
- q Sibling
- q Child, age at cancer diagnosis: __________

Note: The first screening exam should be performed 10 years before the age at which the first-degree relative was diagnosed with cancer.

**Colonoscopy for colorectal cancer screening in STANDARD RISK individual**

- q None
- q Date ____________________
- q Location ____________________
- q Screening required due to age > 50; patient age: __________

Note: Patients with a personal history of hyperplastic polyps, a family history of polyps, colon cancer in one or more second-degree relatives, or a first-degree relative diagnosed with colon cancer at age 60 or older, are considered standard risk individuals.

**Diagnostic colonoscopy for one or more of the following:** (check all that apply)

- q Abdominal pain
- q Constipation
- q Abnormal GI x-ray
- q Diarrhea
- q Changes in bowel habits
- q Diarrhea, presumed infectious
- q Anemia due to G1 blood loss
- q Hematochezia / Melena
- q Dysphagia
- q Hem (±) stool
- q Iron deficiency anemia
- q Other functional GI tract disorders
- q Other signs / symptoms:

**Video Capsule Endoscopy -- small bowel (Patient must first have EGD and colonoscopy for approval by many insurance companies.)**

- q None
- q Date ____________________
- q Location ____________________

**Upper GI Endoscopy for one or more of the following:** (check all that apply)

- q Abdominal pain
- q Abnormal weight loss
- q Anorexia
- q Blood in stool
- q Diarrhea, presumed infectious
- q Dysphagia
- q Feeding difficulties
- q Hematemesis
- q Iron deficiency anemia

Please note, this is page two of a two-page form. Please see page 1 for instructions.

This form can be found online on the UK Physician Portal.

MD-0031 7/12/16

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