Gastro Services & Facilities

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TO TREATING DOCTOR
RE: ANTIPLATELET MEDICATION AND COLONOSCOPY

Dear Dr _____, Date: _____

Re/ Patient Name: _____ Date of Birth: _____

For colonoscopy on ……/……/…… at
Eastern Endoscopy Centre / Sunnybank Private Hospital / Mater Private Hospital.

It is a policy of **Gastro Services & Facilities** that all colonoscopy patients on **anti-platelet medication** (eg. Clopidogrel, Dipyridamole, Prasugrel, Brilinta) must obtain written advice from their treating doctor with respect to **cessation for 7 days prior** to the colonoscopy, or continuation of this medication. If the medication is continued, then a diagnostic colonoscopy will be performed, and no polypectomy (if polyps diagnosed) will be undertaken at this time.

Aspirin is not contraindicated and should be continued or used as a substitute antiplatelet agent.

As the treating doctor, please indicate below your advice regarding this medication.
…….

Date: _____

- ❑ I consider it a low and acceptable risk for the patient to cease _____ (Name of Medication) **7 (SEVEN) DAYS PRIOR TO COLONOSCOPY**.
  The patient has been informed.

  OR

- ❑ I consider it necessary for the patient to continue their medication _____
  and therefore a diagnostic colonoscopy (no polypectomy) will be performed.
  The patient has been informed.

Signed _____ Drs Name _____
(Please print)

Email completed form to EEC.nurse@easternendo.com