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Date: _____

RE: _____ D.O.B. _____

Dear Dr., _____

Your patient listed above has been scheduled for the following procedure:
Colonoscopy/Gastroscopy/ ERCP/ EUS on _____.

They are currently taking blood thinning medication(s) _____, and
we would like permission to hold this/these medications for _____ day(s).

Please fax this back with your recommendations to us, along with any requests such as a
Lovenox bridge, etc. to the fax number indicated.

(585)267-4044 or (585)723-7709

Sincerely,
Rochester Gastroenterology Associates

Recommendations: _____
