CENTER FOR DIGESTIVE HEALTH

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REQUEST FOR PATIENT SERVICES

Patient Name:____D.O.B: ______________

Patient Phone No:________________________________Alt No:____________________

Patient's Insurance *(if Medicare, please see *) :* ____

Referring Dr:____Date: ____________

Doctor Phone No:____________________________________Fax No: ____________________

☐ Office Consultation ☐ Office Visit ☐ Infusion Services

Procedures Requiring Prior Office Consultation:

☐ EUS ☐ Liver Biopsy ☐ Destruction of Hemorrhoids ☐ Capsule Endoscopy ☐ ERCP

Procedures *WITHOUT* Prior Office Consultation:

☐ EGD ☐ Colonoscopy ☐ Flexible Sigmoidoscopy

Please Check Diagnosis:

EGD

☐ Abdominal Pain
☐ Atypical Chest Pain
☐ Anemia
Please supply CBC and Iron studies
☐ Dysphagia or Odynophagia
☐ Persistent vomiting of unknown cause
☐ Reflux persistent or recurring despite therapy
Please supply most recent office notes and medication list
☐ X-Rays suggest suspected neoplastic lesion
☐ Suspected gastric or esophageal ulcer
☐ Suspected upper tract stricture or obstruction
Other: ________________________

Colonoscopy or Flex Sigmoidoscopy

☐ Screening
☐ Hx of Polyps
☐ Anemia, unspecified *
Please supply CBC and Iron studies
☐ Bloating *
☐ Blood in stool
☐ Change in bowel habits
☐ Constipation *
☐ Diarrhea
☐ IBD (Crohn's Ulcerative Colitis)
☐ First Degree Relative with Colon Cancer
☐ Abdominal Pain *
☐ Hx of Colon Cancer
☐ IBS with Diarrhea *
☐ Positive Cologuard
☐ Other: ____________________

**** Indicates Medicare & Medicare Advantage non-coverage diagnoses***

Physician Preference:

Any concerns about your patient having this procedure at an Ambulatory Center?

☐ **YES** ☐ **NO**

Please send any test results or office notes regarding the patient's current issues

Physician Name: ____________________________________

Physician Signature:____Date: __________