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ADMINISTRATOR: BRENDA H. STRICKLAND

FAX completed form to (757) 963-5585 (757) 481-7138
Questions? Call Scheduling at (757) 963-5582 or (757) 481-4817, option 1

Date: __________________

Patient Name: _____________________________ DOB: _________________ SSN: _____________________

Phone: Home _____________________________ Work: _________________ Cell: _____________________

Address: __________________________________ City & Zip Code ___________________________________

Referring Doctor: _________________________ Office Contact: ___________________________________

Referring Dr's Phone ______________________ Referring Doctor Fax: ______________________________

Insurance (Primary) _______________________ ID#: _______________________Group #: _______________

Insurance (Secondary) _____________________ ID# _______________________Group # _______________

REASON REFERRED:

☐ **Consult and Treat**

- ☐ Hematochezia
- ☐ Diarrhea, Constipation, Change in Bowel Habits
- ☐ Dysphagia
- ☐ GERD
- ☐ Abdominal Pain
- ☐ Weight Loss
- ☐ Reflux
- ☐ Anemia

OR

☐ **Screening Colonoscopy Only (no complaints or symptoms)**

- ☐ Screening (age 50+)
- ☐ Family History of Polyps
- ☐ Family History of Colon Cancer
- ☐ Personal History of Polyps
- ☐ Personal History of Colon Cancer

MEDICAL HISTORY: CHECK ALL THAT APPLY

☐ Hospitalizations/Major Illnesses Within Last 3 Months ________________________ (please specify)

- ☐ Diabetic
- ☐ CHF
- ☐ CRF
- ☐ Emphysema/Asthma
- ☐ Oxygen Use
- ☐ ______________________________
- ☐ Coumadin
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Anemia
- ☐ Cane or Wheelchair Use
- ☐ ___________________________________

PLEASE CHECK RECORDS BEING FAXED

- ☐ Most recent H&P
- ☐ Most Pertinent Labs
- ☐ Medication List
- ☐ Radiology Reports
- ☐ Copy of Insurance Card
- ☐ Copy of Insurance Referral (if required)

Thank You For Your Referral!