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ADMINISTRATOR: SHIRLEY K. WOODROW

FAX completed form to (757) 481-7138 or (757) 963-5585

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

OR

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

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

- 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)

- | | |
|---|---|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Coumadin |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> CRF | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Oxygen Use | <input type="checkbox"/> Cane or Wheelchair Use |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

PLEASE CHECK RECORDS BEING FAXED:

- | | | |
|--|---|---|
| <input type="checkbox"/> Most recent H&P | <input type="checkbox"/> Most Pertinent Labs | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Copy of Insurance Card | <input type="checkbox"/> Copy of Insurance Referral (if required) |

Appointment Date: _____ Appointment Time: _____

Location: Will O' Wisp Drive Healthy Way Unable to Reach Patient

Thank You for Your Referral!