



Endoscopic Procedures Referral Form

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

Type of procedure requested: _____

Reason for procedure: _____

Do you want a GI consultation in addition to the endoscopic procedure for this patient?

YES NO

If the procedure reveals significant findings that require treatment or follow up:

- | | | |
|--|-----|----|
| a. Do you want us to treat and follow? | YES | NO |
| b. Special considerations? | YES | NO |

Is the patient on:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Antihypertensive |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insulin |

Does the patient have any of the following Conditions?

- | | |
|---|---|
| <input type="checkbox"/> Heart Valvular abnormalities | <input type="checkbox"/> Valvular prosthesis |
| <input type="checkbox"/> History endocarditis | <input type="checkbox"/> Systemic pulmonary shunt |

Are you aware of any risk factors? YES NO

Significant past history (GI surgery, etc) _____

Have the pre-procedure consult and procedure been scheduled with our office? (If no we will contact the patient to schedule) YES NO

Please fax or send copies of recent office notes, labs, X-Rays, GI-related reports and insurance forms.

Physician Signature: _____