GASTROENTEROLOGY/LOWER GI REQUISITION

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FOR OFFICE USE ONLY

Patient________________________________ DOB____/____/_____ AGE_____ Sex___ SSN____________________ Date____________

Patient Phone #______________Patient Address________________________________ City ______________State __________Zip_______

Primary Insurance______________________________ Policy #__________________________ Group #______________________________

Subscriber______________________________ Relation to Patient____

Secondary Insurance___________________________ Policy #__________________________ Group#_______________________________

Subscriber______________________________ Relation to Patient____

☐ Cash Pay – Family Medicine Residency of Idaho

***** PLEASE USE LETTER OR NUMBER TO MATCH CLINICAL HISTORY AND SOURCE *****

Clinical History (symptoms/screening):

_____ Polyp _____ Mass _____ Pain _____ Diarrhea

_____ Bleeding _____ Inflammatory Bowel Disease _____ Ischemia _____ Hx of Polyps

_____ NSAIDS Other: ____

Duration: ____

Specimen Sources(s):

_____ Random Colon _____ Cecum _____ Transverse _____ Sigmoid

_____ Ileum _____ Ascending _____ Splenic Flexure _____ Rectal

_____ Ileocecal Valve _____ Hepatic Flexure _____ Descending _____ Anal

Subspecialty/Pathology Request

☐ Gastrointestinal Pathology

☐ Attention to Dr.:______________________________________

Physician Name________________________________

Address_______________________________________

Phone #_______________________________________

Fax #____

☐ Fax Report

☐ Phone Report

Copies To:_____________________________________

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____

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MD Signature ________________________________ **DX Code**______________________________________