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ADMINISTRATOR: SHIRLEY K. WOODROW

FAX completed form to (757) 963-5585 or (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**

**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: <input type="checkbox"/> First Colonial Road <input type="checkbox"/> Healthy Way <input type="checkbox"/> Unable to Reach Patient

**Thank You for Your Referral!**