# GASTROENTEROLOGY ASSOCIATES OF CHATTANOOGA, PC

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## DIRECT ACCESS COLONOSCOPY REQUEST FORM

(To be used when no physician office visit necessary)

☐New Patient ☐ Existing Patient

Referring Physician Name: _____ Phone: _____ Fax: _____

Contact person at referring physician's office: _____ Ext. _____

### PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

Insurance Company #1 _____Secondary Ins _____

Patient's Phone: (HM) _____(WK) _____ (Cell) _____

### PROCEDURE INFORMATION

Is this procedure Urgent? ☐ Yes ☐ No. If urgent, patient should come to office to complete paperwork.

☐ Colonoscopy Diagnosis: ☐ Routine colon screening ☐ Presence of fecal occult blood☐ Hematochezia ☐Functional diarrhea
☐ Melena of unknown origin ☐ Personal history of colon polyps ☐Family history of colon cancer ☐Other: _____
_____

☐Panendoscopy Diagnosis: ☐ GERD ☐ Nausea & Vomiting ☐Rule out ulcer ☐ Dysphagia ☐Barrett's Esophagus ☐ Dilitation:
__YES __NO
Other: _____note: Patients needing dilitation will need to see the the physician in the office prior to scheduling procedure.

### Referring Physician's Fax checklist

All information must be received before procedure can be scheduled.
☐ Referral form ☐Hemoccult results☐ Last office notes ☐Labs* ☐ EKG report*
☐ Patient demographic sheet and copy of insurance card
*Labs & EKG required within the last 30 days for Anestesia

### FOR GAC PERSONNEL

Existing Patient: ☐Yes ☐ No Recall Received: ☐Yes ☐ No Patient Account No. _____

Date patient initial contact made: _____ Date information packet mailed: _____
Date received Patient info back: _____
Date of insurance verification _____ Date received information from referring MD: _____

Facility scheduled for procedure:
☐DDEC ☐ Parkridge ☐ Mem ☐ ER ☐Hut Hos ☐ Hut PW
AA: ☐Yes ☐ No Antibiotics? ☐ Yes ☐ No: ☐ Ampicillin 2gmIV ☐Gentamycin 80mgIV ☐ Vancomycin 1gmIV

Miscellaneous: _____

Scheduler: _____ Physician signature: _____

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