

FORT WAYNE ENDOSCOPY CENTER REFERRAL FORM

Fax to: 260/471-7444

Referring Physician: _____

Date: _____

PROCEDURE REQUEST:

Screening Colonoscopy (asymptomatic)

Colonoscopy (no consult)

Upper Endoscopy (no consult)

Diagnosis _____

Diagnosis _____

IF HEALTH PLAN REQUIRES PCP REFERRAL, PLEASE INDICATE TYPE OF REFERRAL AUTHORIZATION _____

Procedure Only
(1 encounter)

Consult/Procedure
(2 encounters)

Consult/Procedure/Follow-Up
(3 encounters)

PATIENT INFORMATION:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: (h) _____ - _____ - _____

(w) _____ - _____ - _____

Insurance: _____

PLEASE FAX COPY OF INSURANCE CARDS

If patient has symptoms, please fax medical information to enable us to authorize the procedure for insurance coverage.

Is patient on blood thinners, i.e. Coumadin, Heparin, Plavix?

No

Yes (If yes, requires consultation)

For questions, call 260/482-8001

or

Toll Free at 877/482-8001

We will contact your patient within 1-2 days of receiving this fax

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