

MILFORD GASTROENTEROLOGY ASSOCIATES, INC.

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REQUIRED INFORMATION

REFERRAL REQUIRED? YES NO

IS THIS AN URGENT REQUEST? YES NO

Patient Name: _____ DOB: _____

Address: _____

Telephone: _____ Referring PCP: _____

PLEASE FAX COPY OF INSURANCE CARD(S), MEDICATION LIST AND LATEST OFFICE NOTE TO OUR OFFICE ALONG WITH THIS REQUEST

TEST(S) REQUESTED: PLEASE CIRCLE

UPPER ENDOSCOPY

GERD resistant to medical mgmt	Abnormal UGI	Dysphagia after barium swallow	Barrett's surveillance
Upper GI bleed	GERD>5 yrs. to r/o Barrett's	Other (please specify) _____	

COLONOSCOPY

Guaiac + stool	Family hx. colon cancer	IBD cancer surveillance	Hx polyps or colon cancer
Abnormal barium enema	Iron deficiency anemia	Chronic diarrhea > 1 month	Lower GI bleed
Colon cancer screening	Other (please specify) _____		

FLEXIBLE SIGMOIDOSCOPY

Hematochezia age < 40 Other (please specify) _____

SPECIAL CONSIDERATIONS

Antibiotic prophylaxis	Prosthetic heart valve	Hx of endocarditis	
Medications	Coumadin	ASA	NSAIDs

BRIEF HISTORY