

Frist Clinic Endoscopy Request

Patient Name _____ Date _____

Home Phone _____ Work _____ Cell _____

Referring Physician Name _____

Referring Physician Telephone Number _____

Dr. Thomas Lewis ____ Dr. Saeed Fakhruddin ____ Dr. Wallace McGrew ____

Dr. Ira Stein ____ Dr. Alan Dopp ____ Dr. Babu Rao ____

Dr. William Alexander ____ First Available ____

Type of Procedure

____ Routine Screening

____ Family History Colon Cancer (must be father, mother, sister or brother)

____ Family History Colon Polyps (must be father, mother, sister or brother)

____ Personal History Colon Cancer

____ Colonoscopy Diagnosis _____

____ Flex Sigmoid Diagnosis _____

____ EGD Diagnosis _____

____ Other (please explain) _____

If patient has had a colonoscopy before, please give the year _____

Comments: _____

**Attach a legible copy of insurance card (s)
and
Patient Demographic Sheet
FAX to (615) 342-6085**

Referring Physician Signature _____

(signature stamp is NOT valid)