The Frist Clinic Endoscopy Request

Patient Name ________________________________ Date ________________

Home Phone ______________ Work ______________ Cell _________________

Referring Physician Name ____

Referring Physician Telephone Number _________________________________

Fax number for the following doctors: **615-342-6084**

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

Fax number for the following doctors: **615-342-5943**

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

PLEASE ATTACH A LEGIBLE COPY OF INSURANCE CARD(S), A DEMOGRAPHIC SHEET AND OBTAIN REFERRAL IF REQUIRED

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: ____

Referring Physician Signature ____
(signature stamp is NOT valid)