GASTROENTEROLOGY ASSOCIATES

Consultative Gastroenterology, Hepatology and Gastrointestinal Endoscopy

WILLIAM F. JOHNSON, M.D., P.C., F.A.C.G.
J. DENNIS GULETZ, M.D., F.A.C.G.
CESAR A. BELLO, M.D.
JOSEPH H. HASEMAN, M.D., F.A.C.G.
GARDAR GISLASON, M.D.
DONALD M. BAILEY, M.D.
VAJRAVEL M. PRASAD, M.D.
SRINIVASAN DUBAGUNTA, M.D.
MICHAEL B. RUSCHE, M.D.
EMERITUS
HERMAN F. RUSCHE, M.D., F.A.C.G.

Fax: 1-866-261-0812

GASTROENTEROLOGY ASSOCIATES REQUEST FOR SERVICES

To: Gastroenterology Associates

If this request is emergent in nature or your patient needs to be seen on an ASAP basis please call our office at (812) 477-6103. We will process your request promptly.

Today's Date: _____

From:

Contact Person: _____ Phone: _____ Ext: _____

Requesting Physician: _____ Fax: _____

Requested Patient Information:

☐ Dr. Johnson ☐ Dr. Guletz ☐ Dr. Bello ☐ Dr. Gislason ☐ *No Preference*

☐ Dr. Bailey ☐ Dr. Prasad ☐ Dr. Dubagunta-Rao ☐ Dr. M. Rusche ☐ *First Available*

Patient Information:

Patient Name: _____ ☐ M ☐ F
First Middle Last (Maiden)

Social Security Number: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Insurance: Primary: _____ Secondary: _____

GI Diagnosis: _____

_____

Service Requested:

- ☐ **Colonoscopy**
- ☐ **Upper Endoscopy (EGD)**
- ☐ **Endoscopic Ultra Sound (EUS)**
- ☐ **ERCP**
- ☐ **Consultation (with a written report back to requesting provider)**
- ☐ **Office Appointment (no report mailed back)**
- ☐ **Other:** _____

Please include recent labs, radiology reports, office notes, and op reports as well as a copy of the patient's insurance card(s).

For Office Use Only

☐ New ☐ Established ☐ ASAP _____

Chart #: _____ ____New label

Date: _____Time: _____Initials: _____

Requesting Physician #: _____

Family Physician: _____

Note: _____

_____

GA193