GASTROENTEROLOGY ASSOCIATES

Consultative Gastroenterology, Hepatology and Gastrointestinal Endoscopy

REQUEST FOR SERVICES FORM

Fax to: 1-866-261-0812

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 promptly process your request.

Today's Date: _____

From:

Contact Person: _____ Phone: _____ Ext: _____

Requesting Physician: _____ Fax: _____

Requested Patient Information:

☐ Dr. Johnson ☐ Dr. Gislason ☐ Dr. Bailey ☐ Dr. Prasad ☐ *No Preference*

☐ Dr. Dubagunta-Rao ☐ Dr. M. Rusche ☐ Dr. Khan ☐ *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)**
- ☐ **Lower Endoscopic Ultrasound (EUS)**
- ☐ **Upper Endoscopic Ultrasound**
- ☐ **ERCP**
- ☐ **Consultation (with a written report back to requesting provider)**
- ☐ **Office Appointment (no report mailed back)**
- ☐ **Other :** _____

Please include recent lab and/or 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: _____

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