Madison County Memorial Hospital

REFERRAL FOR ENDOSCOPY SERVICES

DATE: ____________________

FAX TO: MADISON COUNTY MEMORIAL HOSPITAL PHONE: 850-253-1964

ENDOSCOPY DEPARTMENT FAX: 850-973-2937

FROM: ____________________ PHONE: ____________________ FAX: ____________________

PATIENT INFORMATION

LAST NAME: ____________________ FIRST NAME: ____________________

DATE OF BIRTH: ____________________ PHONE NUMBER: ____________________

PROCEDURE REQUESTED: ☐ SCREENING COLONOSCOPY

☐ DIAGNOSTIC COLONOSCOPY ICD 10: ____________

☐ EGD

☐ OTHER ____________________

PLEASE INCLUDE THE FOLLOWING WITH REFERRAL

☐ PATIENT DEMO SHEET WITH INSURANCE INFORMATION

☐ H&P / LAST OFFICE VISIT NOTE

☐ CURRENT MEDICATION LIST

PLEASE NOTE IF PATIENT HAS A BMI >60 AND OR OVER 80 YRS OF AGE, PATIENT WILL NOT BE A CANDIDATE TO HAVE PROCEDURE PERFORMED AT OUR FACILITY