



Madison County Memorial Hospital

REFERRAL FOR ENDOSCOPY SERVICES

DATE: _____

TO: MADISON COUNTY MEMORIAL HOSPITAL

PHONE: 850-253-1764

ENDOSCOPY DEPARTMENT

FAX: 850-473-2807

FROM: _____ PHONE: _____ FAX: _____

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ PHONE NUMBER: _____

PROCEDURE REQUESTED: ☐ SCREENING COLONOSCOPY

☐ DIAGNOSTIC COLONOSCOPY ICD # _____

☐ EGD

☐ OTHER _____

PLEASE INCLUDE THE FOLLOWING WITH REFERRAL

☐ PATIENT DEMO SHEET WITH INSURANCE INFORMATION

☐ HEP / LAST OFFICE VISIT NOTE

☐ CURRENT MEDICATION LIST

PLEASE NOTE IF PATIENT HAS A BMI -40 AND OR OVER 60 YRS OF AGE, PATIENT WILL NOT BE A CANDIDATE TO HAVE PROCEDURE PERFORMED AT OUR FACILITY

NOTES: THIS FACTORIAL TRANSMISSION CONTAINS CONFIDENTIAL INFORMATION. NONE OR ALL OF WHICH MAY BE PROTECTED BY FEDERAL OR STATE LAWS OR BY THE FEDERAL HEALTH CARE PRIVACY ACT. THIS INFORMATION IS PROVIDED FOR THE EXCLUSIVE USE OF THE ADDRESSEE OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PROPRIETARY, UNPUBLISHED, CONFIDENTIAL, OR SUBJECT TO OTHER LAWS, REGULATIONS, OR CONTRACTS. UNLAWFUL DISCLOSURE OR USE IS PROHIBITED.