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 >40 AND OR OVER 80 YRS OF AGE, PATIENT WILL NOT BE A CANDIDATE TO HAVE PROCEDURE PERFORMED AT OUR FACILITY

IMPORTANT: THIS FACSIMILE TRANSMISSION CONTAINS CONFIDENTIAL INFORMATION, SOME OR ALL OF WHICH MAY BE PROTECTED HEALTH INFORMATION AS DEFINED BY THE FEDERAL HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE. THIS TRANSMISSION IS INTENDED FOR THE EXCLUSIVE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PROPRIETARY, PRIVILEGED, CONFIDENTIAL AND/OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW.