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