UNIVERSITY MEDICAL CENTER
THE UNIVERSITY OF TOLEDO

Name:
DOB:
MR #

ENDOSCOPY SUITE
DIRECT ENDOSCOPY REQUEST

Ali Nawras, M.D.
Thomas Sodeman, M.D.
Wael Youssef, M.D.

REFERRING PHYSICIAN:_____PHONE #_____
_____FAX #_____

Special requests:_____
_____

CHECK REQUESTED PROCEDURE(S) AND ALL APPLICABLE INDICATIONS:

_____ COLONOSCOPY (Indications)

_____ Colon cancer screening (> 50 yo)
_____ Personal history of colon cancer (date of surgery _____)
_____ Personal history of colon polyps (date of last colonoscopy_____)
_____ Family history of colon cancer – who _____
_____ Family history of colon polyps – who _____ 1st degree relative
_____ Abnormal barium enema or CT (attach report)
_____ Change in bowel habits
_____ Occult GI bleeding
_____ Hematochezia
_____ Melena with negative EGD
_____ Iron deficiency anemia (attach labs)
_____ Other:_____

_____ EGD (Indications)

_____ Melena
_____ GERD
_____ Dysphagia
_____ Epigastric pain unresponsive to treatment
_____ Iron deficiency anemia with negative colonoscopy
_____ Occult GI bleeding with negative colonoscopy
_____ Abnormal UGI, x-ray or CT (attach report)
_____ Nausea and/or vomiting
_____ Other: _____

PERTINENT MEDICAL HISTORY:

Yes	No		Yes	No	
____	____	Cardiac arrhythmia	____	____	Congestive heart failure
____	____	Renal failure	____	____	Prosthetic heart valve
____	____	Pacemaker	____	____	AICD
____	____	Oxygen dependency	____	____	Dementia or other mental/ physical handicap
____	____	GI tract surgery			
____	____	Obstructive sleep apnea			

MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____ Home Phone:_____

Address: _____ Work Phone:_____
_____

Date of Birth:_____ Social Security #:_____

INSURANCE INFORMATION: (may attach photocopy of insurance card)

Plan Name:_____

Group Name:_____

Insured Name:_____

Insurance ID #:_____

Secondary Insurance:_____

FAX COMPLETED FORM TO 419-383-5778

Gastroenterology/Hepatology Physician Signature_____