



Procedure Scheduling Form
EGD – Colonoscopy

**Please forward any pertinent: Labs, Office Notes,
 Radiology Reports, CT Scans along with
 Insurance Cards, and Medication List.**

In order for us to provide you and your patient timely and efficient service, we ask that you complete this form and fax to our Scheduling Department at **(515) 288-8335**.

From which provider in our practice are you requesting services? (Please **circle one** below.)

- | | | | |
|----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------------|
| <input type="radio"/> Dr. Iyer | <input type="radio"/> Dr. Leman | <input type="radio"/> Dr. Lopes | <input type="radio"/> Dr. Martin |
| <input type="radio"/> Dr. Myneni | <input type="radio"/> Dr. O'Brien | <input type="radio"/> Dr. Roberts | <input type="radio"/> Dr. Vemulapalli |
| <input type="radio"/> Dr. Verma | <input type="radio"/> Dr. Mulder | <input type="radio"/> Dr. Sondhi | <input type="radio"/> Any IDDC Provider |

Patient Information

Referring Provider: _____ Phone: _____

Person Making this Request: _____ Fax: _____

Has the patient been seen by any GI provider in the office or hospital?

- Yes No If yes, by whom? _____

Patient Name: _____ DOB: _____ Circle: Male Female

Patient's Street Address: _____ City: _____ State: ____ Zip Code: _____

Patient's Phone: _____ Circle: Work / Cell / Other

Patient's Weight: _____ Patient's Height: _____

Does the patient read and understand the English language: Yes No

Is a sign language/or language translator needed?

- No Yes If yes, which language? _____

Procedure Information

What is the procedure to be scheduled?

- Colon Screening Colon Diagnostic EGD Other: _____

If Diagnostic Colon: (Please **circle all** that apply.)

- Abdominal Pain Blood in Stool
 Change in Bowel Habits Constipation
 Family Hx of Colon Cancer or Polyps Diarrhea

If for EGD: (Please **circle all** that apply.)

- Nausea/Vomiting GERD
 Barret's Esophagus
 Other:

Is the patient on Anticoagulants or Aspirin?: No Yes Prescribed by whom? _____

Insurance Information (Include a copy of card with referral.)

Primary Insurance: _____ Insurance ID#: _____ Self or Other: _____

Secondary Insurance: _____ Insurance ID#: _____ Self or Other: _____