SUMMIT PACIFIC
• MEDICAL CENTER •

Endoscopy Procedure Referral

Phone: 360-495-5780 **Fax: 360-495-5781**

Patient Information

Height _____ Weight _____ BMI _____

Patient last name: _____ First: _____ MI ___ DOB: _____ Age: ____ Sex: _____

Patient Address: _____ City/State: _____ Zip: _____

Home #: _____ Work #: _____Cell#: _____ Email: _____

Referral Information

Referring Provider: _____ Location: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Diagnosis: _____ ICD 10: _____

Primary Insurance: _____ Coverage eligibility phone: _____

Member ID #: _____ Group #: _____ Effective Date: _____

Colonoscopy

- ☐ Screening: 45 years or older with average age risk

Specific indications:

- ☐ Personal hx of polyps. Type: _____
  - Colonoscopy date: _____
- ☐ Personal hx of colorectal cancer
  - Last colonoscopy date: _____
- ☐ Personal hx of inflammatory bowel disease
- ☐ Family hx of colorectal cancer or polyps
  - Relation _____ Age at dx___
  - Relation _____ Age at dx___
- ☐ Fecal occult blood positive, date _____
- ☐ Iron deficiency
- ☐ Hematochezia (rectal bleeding)
- ☐ Other, describe _____

Flexible Sigmoidoscopy

- ☐ Screening
- ☐ Suspected rectal disease when colonoscopy is not indicated

EGD (Upper Endoscopy)

- ☐ Upper abdominal distress/dyspepsia
- ☐ Dysphagia/Odynophagia (circle one)
- ☐ Nausea/vomiting
- ☐ Gastric ulcer
- ☐ Hiatal Hernia
- ☐ Gastrointestinal bleed/iron deficiency with suspected upper GI source
- ☐ Barrett's esophagus surveillance
  - Date of last EGD _____

****Submission *must* include the following information:**

- ☐ **Patient face sheet**
- ☐ **List of current medications**
- ☐ **Surgical and medical history**
- ☐ **Recent history and physical**
- ☐ **Endoscopy Procedure reports if applicable**