Eugene Gastroenterology
CONSULTANTS, P.C.

PATIENT REQUISITION FORM

Fax # (541) 685-5920
Phone # (541) 868-9500

FIRST NAME: ____________________ MI: ______ LAST NAME: ____________________

GENDER: ☐ MALE ☐ FEMALE DATE OF BIRTH (OVER 18 YRS ONLY): ______________ SOCIAL SECURITY #: ______________

HOME PHONE: ______________ CELL PHONE: ______________ WORK PHONE: ______________

REFERRING PROVIDER: ____________________ PHONE: ______________ FAX: ______________

PCP NAME: ____________________ PHONE: ______________ FAX: ______________

PRIMARY INSURANCE: ____________________ ID #: ______________ GROUP #______________

SECONDARY INSURANCE: ____________________ ID #: ______________ GROUP #______________

DOES PATIENT'S INSURANCE REQUIRE A REFERRAL? ☐ YES (PLEASE PROCESS AND SEND WITH THIS FORM) ☐ NO

Referral will NOT be processed until all required information is sent

RECORDS

MEDICAL RECORDS ARE REQUIRED! WE CANNOT PROCESS THE REFERRAL WITHOUT THEM.

HAS THE PATIENT HAD ANY OF THE FOLLOWING? IF YES, RECORDS **MUST** BE INCLUDED.

PROCEDURES

- COLONOSCOPY/EGD
  - ☐ YES (RECORDS INCLUDED) ☐ NO
- WERE BIOPSIES TAKEN?
  - ☐ YES (PATHOLOGY REPORT INCLUDED, SEPARATE FROM PROCEDURE RECORDS)
  - ☐ NO

IMAGING

☐ YES (RECORDS INCLUDED) ☐ NO

LABS

☐ YES (RECORDS INCLUDED) ☐ NO

RECORDS LOCATED: ☐ ATTACHED ☐ MAILED ☐ PEACEHEALTH EMR ☐ NSC EMR ☐ OMG EMR

PRIORITY

☐ NEXT AVAILABLE (NON-URGENT) ☐ URGENT (1-2 WKS) – REQUIRES DIRECT PROVIDER TO PROVIDER COMMUNICATION

PROVIDER

☐ FIRST AVALABLE MD OR NP/PA
(USUALLY RESULTS IN EARLIER APPOINTMENT TIMES)

☐ MD ONLY – NO NP/PA PLEASE
(IF MD ONLY OR A SPECIFIC PROVIDER ARE SELECTED, ANTICIPATE LONGER WAIT TIME FOR APPOINTMENT)

☐ PETER KAY, MD OR NP/PA
☐ WILLIAM WU, MD OR NP/PA
☐ DONALD YANG, MD OR NP/PA
☐ JONATHAN GONENNE, MD OR NP/PA
☐ SHANE MILLS, MD OR NP/PA
☐ DAVIS SIM, MD, PHD OR NP/PA

☐ TAHMINA HAQ, MD OR NP/PA
☐ JUBEEN MOAVEN, MD OR NP/PA
☐ PAGE CRENSHAW, FNP
☐ AMY LITTLEJOHN, PA-C
☐ MALLORY FILLMORE, PA-C

REASON FOR EVALUATION

SYMPTOMS WARRANTING REFERRAL OR REASON FOR EVALUATION AND MANAGEMENT BY EUGENE GASTROENTEROLOGY CONSULTANTS. PLEASE BE AS SPECIFIC AS POSSIBLE, WITH AS MUCH DETAIL AS AVAILABLE REGARDING SYMPTOMS, SIGNS, TEST RESULTS, AND PRIOR EVALUATION.

COMMENTS: ____

CONTACT PERSON: ____________________ PHONE #: ______________ DATE: ______________

CONFIDENTIALITY NOTICE

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10/13/17 ke/aw (replaces 07/12/16 ke)

To print the most current form, go to www.eugenegi.com