



Eugene Gastroenterology Consultants, P.C.

PATIENT REQUISITION FORM

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

PATIENTS' NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

HOME PHONE #: _____ WORK PHONE #: _____

OTHER PHONE #: _____ EMPLOYER: _____

PRIMARY INSURANCE: _____ ID# _____ GROUP #: _____

SECONDARY INSURANCE: _____ ID# _____ GROUP #: _____

REFERRING MD: _____ PHONE #: _____ FAX #: _____

PCP NAME: _____ PHONE #: _____ FAX #: _____

MEDICAL RECORDS ARE REQUIRED!! (INCLUDING LABS AND X-RAY REPORTS):

- ATTACHED MAILED CARECAST NSC EMR IC CHART

EACH SECTION BELOW MUST BE COMPLETED FULLY TO AVOID DELAY IN SCHEDULING.

PROVIDER REQUESTED: <input type="checkbox"/> FIRST AVAILABLE MD OR ANP _____ <input type="checkbox"/> GREGORY KNECHT, MD OR NP <input type="checkbox"/> CHRISTIANNE KRATKA, MD OR NP <input type="checkbox"/> DANIEL PHILLIPS, MD OR NP <input type="checkbox"/> CRAIG CHAMBERLAIN, MD OR NP <input type="checkbox"/> PETER KAY, MD OR NP <input type="checkbox"/> WILLIAM WU, MD OR NP <input type="checkbox"/> DONALD YANG, MD OR NP <input type="checkbox"/> JONATHAN GONENNE, MD OR NP <input type="checkbox"/> KIMBERLY HANSON, ANP <input type="checkbox"/> SUZANNE WEBBER, NP _____ <input type="checkbox"/> MD ONLY PLEASE	REQUEST FOR: <input type="checkbox"/> CONSULTATION SYMPTOMS/DIAGNOSIS (PLEASE BE COMPLETE) _____ _____ _____ <input type="checkbox"/> SCREENING COLONOSCOPY (I.E., ABSOLUTELY NO SYMPTOMS OR SIGNS OF ABNORMALITY) PT'S FAMILY HX OF COLON CA: (WHO, AGE) _____ DATE OF PRIOR COLONOSCOPY: (MO/YR) _____ <input type="checkbox"/> NONE DATE OF PRIOR FLEX SIG: (MO/YR) _____ <input type="checkbox"/> NONE	TIMEFRAME: <input type="checkbox"/> WITHIN 2 WKS <input type="checkbox"/> WITHIN 6 WKS <input type="checkbox"/> NEXT AVAILABLE (NON-URGENT) <i>NOTE: ANY SERVICE NEEDED WITHIN 1 WEEK WILL REQUIRE DIRECT MD-TO-MD COMMUNICATION</i>
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COMMENTS: _____

CONTACT PERSON: _____ PHONE # _____ DATE: _____

CONFIDENTIALITY NOTICE

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