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) _____ EGD (Indications)

_____ Colon cancer screening (> 50 yo) _____ Melena

_____ Personal history of colon cancer _____ GERD

_____ (date of surgery ____________) _____ Dysphagia

_____ Personal history of colon polyps _____ Epigastric pain unresponsive
to treatment

_____ (date of last colonoscopy__________) _____ Iron deficiency anemia with
negative colonoscopy

_____ Family history of colon cancer – who_____ Occult GI bleeding with
negative colonoscopy

_____ Family history of colon polyps – who_______ Abnormal UGI, x-ray or CT
_____ 1st degree relative (attach report)

_____ Abnormal barium enema or CT (attach report)

_____ Change in bowel habits _____ Nausea and/or vomiting

_____ Occult GI bleeding _____ Other: ________________________

_____ Hematochezia

_____ Melena with negative EGD

_____ Iron deficiency anemia (attach labs)

_____ Other: ______________________________________

PERTINENT MEDICAL HISTORY:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Cardiac arrhythmia</td>
<td></td>
<td>Congestive heart failure</td>
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<td>Renal failure</td>
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<td>Prosthetic heart valve</td>
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<td>Pacemaker</td>
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<td>AICD</td>
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<td>Oxygen dependency</td>
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<td>Dementia or other mental/physical handicap</td>
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<td>GI tract surgery</td>
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<td>Obstructive sleep apnea</td>
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MEDICATIONS: ____________________________  ALLERGIES: ____________________________
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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 ________________________________