MID-AMERICA GASTRO-INTESTINAL CONSULTANTS, P.C.
Allen – Culver – Helzberg – McCullough
4321 Washington, Suite 5600, Building III
Kansas City, MO 64111
816/561-2000 FAX 816/931-1758

SCHEDULING REQUEST FORM

PATIENT: _____

DATE OF BIRTH: _____HOME PHONE: _____

WORK PHONE: _____CELL PHONE: _____

TYPE OF APPOINTMENT:

_____CONSULTATION – not same day of procedure **ROUTINE _____**

_____EGD/UPPER ENDOSCOPY **URGENT _____**

_____COLONOSCOPY

_____FLEXIBLE SIGMOIDOSCOPY

_____H-PYLORI BREATH TEST

_____ PILL CAM

PLEASE INCLUDE INDICATIONS FOR APPOINTMENT: _____

IS PATIENT TAKING ANY ANTI-COAGULANT MEDICATIONS?
YES _____ NO _____ WHAT TYPE? _____

IF YES, ANY PATIENTS ON ANTI-COAGULANTS NEED AUTHORIZATION FROM MONITORING PHYSICIAN TO STOP THE MEDICATION FOR 3 DAYS PRIOR TO PROCEDURE. PLEASE NOTIFY THIS OFFICE WITH THE AUTHORIZATION.

MEDICATION ALLERGIES: _____

*****INCLUDE HISTORY AND PHYSICAL EXAMS, PERTINENT TEST RESULTS AND CHART NOTES**

INSURANCE COMPANY: _____

PATIENT ID# _____GROUP OR ACCOUNT # _____

IF POSSIBLE, INCLUDE LEGIBLE COPIES OF INSURANCE CARDS

REFERRING PHYSICIAN NAME: _____

OFFICE PHONE: _____FAX PHONE: _____

THANK YOU FOR YOUR REFERRAL