

Charleston

GASTROENTEROLOGY Specialists

Goose Creek
149 St. James Avenue
Goose Creek, SC 29445

Summerville
103 A Harth Place
Summerville, SC 29485

Phone: 843-722-8000

Mt. Pleasant
180 Wingo Way, Suite 305
Mt. Pleasant, SC 29485

West Ashley
1962 Charlie Hall Blvd.
Charleston, SC 29414

Fax: 843-723-7850

APPOINTMENT REQUEST FORM

Urgent Routine

Requesting Provider Information

Requested by: _____

Contact Information: Phone: _____ Fax: _____

Patient Information

Patient Name: _____ DOB: _____ SS# _____

Patient Address: _____

Patient Phone Number: (H) _____ (W) _____ (Cell) _____

Insurance Referral/Authorization # (If required by insurance): _____

Reason for Appointment

Consultation to evaluate and treat:

- | | | | | |
|---|------------------------------------|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> GERD | <input type="checkbox"/> N/V | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> GI Bleed: | <input type="checkbox"/> Upper | <input type="checkbox"/> Lower | <input type="checkbox"/> Unsure |
| <input type="checkbox"/> Other _____ | | | | |

and/or

- | | | | | |
|--|-----------------------------|-------------------------------------|------------------------------|---------------------------------------|
| <input type="checkbox"/> Abnormal Imaging: | <input type="checkbox"/> CT | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> UGI | <input type="checkbox"/> Barium enema |
|--|-----------------------------|-------------------------------------|------------------------------|---------------------------------------|

Procedure: Screening/ Surveillance Colonoscopy:

age>50 **Family hx colon:** polyps cancer **Personal hx colon:** polyps cancer

Schedule Preference:

Brener Corless Gourdin Hadzijahic Iriens Jr. Noble Royall Smith

We will schedule your patient an appointment and fax this sheet back to you with the date and time. In the meantime, **please provide us with any pertinent records such as office notes, imagery studies, labs or hospital records.** Please fax a copy of the patient's insurance card and referral authorization (if required). **Thank You For Your Referral!**

CGS use ONLY –

_____	_____	_____	_____	_____
Appt. Date & Time	Physician	Return Fax Date	Packet Mailed Date	Initials
<input type="checkbox"/> Left Message for patient to contact office for appointment:		_____ (Date)	_____ (Initials)	
<input type="checkbox"/> Referral letter mailed to patient to contact office:		_____ (Date)	_____ (Initials)	