SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

Website: Syracusegastro.com

Appointment Request

☐ **STAT**

Date _____

Patient Name_____Date of Birth_____

SSN_____ Maiden Name_____ Age_____

Home phone_____ Cell_____ Other_____

Address_____

□ English □ **Translator needed? (language)**_____ Patients email _____

Primary insurance _____

ID #_____ Group/plan # _____ **CIN#**_____

Is a referrals needed? ☐ **NO** ☐ **YES** Ref # _____ # of visits _____ Valid Dates _____

Secondary insurance _____

ID #_____ Group/plan # _____ **CIN#**_____

Is a referrals needed? ☐ **NO** ☐ **YES** Ref # _____ # of visits _____ Valid Dates _____

APPOINTMENT TYPE: ***FAX BACK TO: 234-6696 OR 234-4808***

☐ COLON SCREENING (NO SYMPTOMS)

☐ SYMPTOMS _____

☐ PREVIOUS GASTRO DOCTORS NAME: _____

LOCATION REQUESTED: ☐ ANY OFFICE ☐ SYRACUSE ☐ CLAY ☐ CAZENOVIA

Referring Doctor: _____

From: _____ Phone _____ Fax _____

MISSING INFORMATION MAY DELAY YOUR REFERRAL. PLEASE INCLUDE:

* DEMOS AND INS. REFERRAL
* LAST OV NOTE AND H&P
* LABS
* **HEPATITIS OR LIVER PATIENT** REFERRALS: PLEASE FAX 2 YEARS WORTH OF LABS
* IMMUNIZATION RECORD
* ALL PREVIOUS GASTRO RECORDS
* ANY OTHER TESTING DONE
* LAST CARDIOLOGIST NOTE
* RADIOLOGY (OLD AND NEW)
* **IBD PATIENTS:** PLEASE SEND LAST DEXA SCAN

10/2017