



**DARTMOUTH-HITCHCOCK**  
NASHUA

**GASTROENTEROLOGY**

21 East Hollis St, Nashua, NH 03060 PHONE 603-577-4081 FAX 603-577-4277

Today's Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

PCP: \_\_\_\_\_

**\*\*COMPLETE THE FOLLOWING INSURANCE INFORMATION or YOU MAY ATTACH A COPY OF THE PATIENTS DEMOGRAPHIC SHEET and INSURANCE CARD (front & back).**

Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Effective Date: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ CO-PAY \$: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**\*\*If your Patient has a Managed Care Insurance Plan, please submit a referral and FAX to 603-577-4388**

**DUAL REQUESTS – PLEASE INDICATE ORDER PREFERENCE (#1, #2)**

**OFFICE CONSULTATION**

Please FAX ALL Office notes, Reports, Labs, etc. to 603-577-4277.

DIAGNOSIS: \_\_\_\_\_

TESTING DONE:

|  |  |  |
|--|--|--|
| <input type="checkbox"/> <b>EGD</b><br><br><input type="checkbox"/> Abdominal Pain<br><input type="checkbox"/> Abnormal Radiographic Testing<br><br><input type="checkbox"/> Celiac Disease Confirmation<br><br><input type="checkbox"/> Dyspepsia<br><input type="checkbox"/> Dysphagia<br><br><input type="checkbox"/> Gastric Ulcer F/U<br><input type="checkbox"/> GERD<br><input type="checkbox"/> GI Bleed<br><br><input type="checkbox"/> Iron Deficiency<br><br><input type="checkbox"/> Screening Barrett's Esophagus | <input type="checkbox"/> <b>DIAGNOSTIC COLONOSCOPY</b><br><br><input type="checkbox"/> Abnormal Radiographic Testing<br><br><input type="checkbox"/> Chronic Diarrhea<br><input type="checkbox"/> Chronic Constipation<br><br><input type="checkbox"/> FU Diverticulitis<br>-after 2 mo TX completion<br><br><input type="checkbox"/> GI Bleed<br><br><input type="checkbox"/> Hemocult Positive Stool<br><br><input type="checkbox"/> Iron Deficiency<br><br><input type="checkbox"/> Personal HX Colon Cancer<br><input type="checkbox"/> Personal HX Colon Polyps | <input type="checkbox"/> <b>SCREENING COLONOSCOPY</b><br><br><b>OPTION 1:</b><br>Attend our Group Informational Meeting AT 21 EAST HOLLIS STREET<br><br><input type="checkbox"/> FM HX Colon CA<br>-1 <sup>st</sup> Degree relative or multiple 2 <sup>nd</sup> degree relatives<br><br><input type="checkbox"/> Previous screening colonoscopy- Year _____<br><br><p align="center"><b>OR</b></p> <b>OPTION 2:</b><br>View our On-line Colonoscopy Information via the Internet:<br><a href="http://www.dartmouth-hitchcock.org/nashua/goto/colonoscopyonline/">http://www.dartmouth-hitchcock.org/nashua/goto/colonoscopyonline/</a> |
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**INFORMATION NEEDED FOR PROCEDURES ONLY**

|                                     |     |    |
|-------------------------------------|-----|----|
| RENAL / KIDNEY DISEASE?             | YES | NO |
| DIABETES?                           | YES | NO |
| Taking COUMADIN?                    | YES | NO |
| May stop 5 days prior to procedure? | YES | NO |
| Taking PLAVIX, ASPIRIN or NSAIDS?   | YES | NO |
| May stop 7 days prior to procedure? | YES | NO |