The Frist Clinic Endoscopy Request

Patient Name _____DOB:_____ Date _____

Home Phone _____ Work _____ Cell _____

Referring Physician Name _____

Referring Physician Telephone Number _____

Fax number: **615-342-5943**

Dr. Thomas Lewis ___ Dr. Saeed Fakhruddin ___ Dr. Wallace McGrew ___

Dr. Ira Stein ___ Dr. Jonathan Schneider ___ Dr. Matthew Neff ___

PLEASE ATTACH A LEGIBLE COPY OF INSURANCE CARD(S), A DEMOGRAPHIC SHEET AND OBTAIN REFERRAL IF REQUIRED

Type of Procedure

___ Routine Screening

___ Family History Colon Cancer (must be father, mother, sister or brother)

___ Family History Colon Polyps (must be father, mother, sister or brother)

___ Personal History Colon Cancer

___ Colonoscopy Diagnosis _____

___ Flex Sigmoid Diagnosis _____

___ EGD Diagnosis _____

___ Other (please explain) _____

If patient has had a colonoscopy before, please give the year _____

Comments: _____

Referring Physician Signature _____
(signature stamp is NOT valid)