Digestive Care Center

Surgical Care Associates

REQUEST FOR SERVICES FORM

Fax to: 1-866-202-4492

If this request is emergent in nature or your patient needs to be seen on an ASAP basis please call our office at (812) 477-6103. We will promptly process your request.

Today's Date: _____

From:

Contact Person: _____ Phone: _____ Ext: _____

Requesting Physician: _____ Fax: _____

Requested Physician:

General Surgery

☐ Dr. Alapati

Ohio Valley Colon and Rectal Surgeons

☐ Dr. Waller ☐ Dr. Smith

☐ Dr. Chilukuri ☐ Dr. Arruffat

☐ *First Available* ☐ *No Preference*

Patient Information:

Patient Name: _____ ☐ M ☐ F

First Middle Last (Maiden)

Social Security Number: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Insurance: Primary: _____ Secondary: _____

Diagnosis: ☐ Abd pain ☐ Bleeding ☐ Diarrhea ☐ Hem + Stool
☐ Rectal pain ☐ Change in Bowel Habits ☐ Constipation
☐ Blood in Stool ☐ Other: _____

Service Requested:

☐ **Colonoscopy**
☐ **Rectal EUS**

☐ **Surgical Consultation (with a written report back to requesting provider)**

☐ **Other :** _____

Please include recent lab and/or radiology reports, office notes, and op reports as well as a copy of the patient's insurance card(s).

For Office Use Only

☐ **New** ☐ **Established** ☐ **ASAP**

Date: _____ **Time:** _____

Chart #: _____ **Taken by:** _____

Requesting Physician : _____

Family Physician: _____

Note: _____

How did you hear about us? _____

GA193C