Digestive Care Center
+ DIGESTIVE URGENT CARE

REQUEST FOR SERVICES FORM

Fax to: 1-866-202-4492

Today's Date: _____

From:

Contact Person: _____ Phone: _____ Ext: _____

Requesting Physician: _____ Fax: _____

Requested Physician:

EVANSVILLE GI

☐ Dr. Gislason ☐ Dr. Bailey ☐ Dr. Prasad ☐ Dr. Rao

☐ Dr. M. Rusche ☐ Dr. Khan ☐ Dr. Pugh

☐ *First Available Provider*

JASPER ☐ Dr. Snyder

PEDIATRIC GI ☐ Dr. Carey

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) with this referral.

Patient Information:

Patient Name: _____ ☐ M ☐ F

First Middle Last (Maiden)

DOB: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Insurance: Primary: _____ Secondary: _____

GI Diagnosis: _____

_____

Is this referral urgent or emergent? If so, please call 812-477-6103

Service Requested:

- ☐ **Colonoscopy**
- ☐ **Upper Endoscopy (EGD)**
- ☐ **Lower Endoscopic Ultrasound (EUS)**
- ☐ **Upper Endoscopic Ultrasound (EUS)**
- ☐ **ERCP**
- ☐ **Consultation**
- ☐ **Nutritional Services**
- ☐ **Other :** _____

For Office Use Only

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

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

Note: _____

_____

_____

_____

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