

Ravish Mahajan, MD
Board Certified in Gastroenterology

5 Executive Drive, Suite B-1 Lafayette, IN 47905 PH: 765.807.0531 FX: 765.807.0534

() in 1-2 days (Urgent) () in 1 week (ASAP) () in 1-2 weeks (Routine)

Referral date: _____ Form filled by: _____

Patient name: _____ Tel: _____

Address: (or, send complete demographic sheet with this fax) Cell: _____

Insurance: _____

DOB: _____ Age: _____

Allergy: _____ Referring MD: _____

Sex: Male/ Female Provider telephone no : _____

Provider fax number : _____

Previous EGD: ____/____/____ Previous colonoscopy: ____/____/____

() Office consultation (Reason: _____)

(For patients over 80 years, please make a clinic appointment)

*Same week appointments available

*Saturday clinic appointments available

() Screening Colonoscopy:

- | | |
|---|--|
| () Screening colonoscopy, average risk, age 50+ | () high risk screening colonoscopy |
| () Heme positive on Annual Physical | () personal history of colon cancer |
| () Personal history of polyps (Type: adenomatous/hyperplastic <i>circle one</i> , Date:____/____/____) | |
| () Family history of colon cancer | () Family history of adenomatous polyps |
| () Lynch syndrome | () Familial adenomatous polyposis |

() Diagnostic Colonoscopy: Reason _____

() EGD: Reason _____

Notes: _____

Weight: _____ lbs Pacemaker /AICD Yes/No Blood thinner : _____

PLEASE FAX ALONG WITH THIS FORM:

- Both sides of insurance card
- Last progress note, labs, xrays, CT, EKG
- List of current medications
- Demographic sheet

For LG office use only:

