GANNAMANENI
Gastroenterology
A UNITY HEALTHCARE PARTNER

Date of Referral:_____ Requested Physician: ☐ Gannamaneni

Patient Name:_____ Email:_____

Address:_____ **Height:**_____**Weight:**_____ **BMI:**_____
_____

Date of Birth:_____ Consult:_____

Cell Number:_____ Diagnosis:_____

Home Number:_____ Procedure:_____
Please Attach Last EKG.

	YES	NO
Any Heart Problems	☐	☐
History of Endocarditis	☐	☐
Heart Valve Surgery	☐	☐
Diabetes	☐	☐
Lung Problems	☐	☐
Home Oxygen	☐	☐
Kidney Problems	☐	☐
Dialysis Patient	☐	☐
Liver Problems	☐	☐
Coumadin	☐	☐

Anti-platelets:_____
_____
(Plavix, Aspirin, NSAIDS)

Reason for Anti-platelets/Coumadin:
_____
_____

Prescribed by:_____

Referring Physician:_____

Phone Number:_____

Fax Number:_____

	YES	NO
Personal Hx of Colon Polyps	☐	☐
Personal Hx of Colon Cancer	☐	☐
Family Hx of Colon Polyps	☐	☐
Family Hx of Colon Cancer	☐	☐

Date of Previous Endoscopy:_____
(attach copy if available)

Allergies to Medications:
_____
_____
_____

PLEASE FAX COMPLETED FORM, LAST OFFICE VISIT, READABLE LIST OF MEDICATIONS AND COPIES OF INSURANCE CARDS TO 765.807.2789.