



4851 Northshore Lane, Suite B
North Little Rock, AR 72118
Ph: (501) 225-1400
Fax: (501) 225-1401

FOR INTERNAL USE ONLY

PHYSICIAN INFORMATION

CLINIC NAME: _____
STREET ADDRESS: _____
SUITE: _____ CITY: _____
STATE: _____ ZIP: _____
PHONE: _____
FAX: _____
OFFICE CONTACT: _____

☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____
☐ _____
NPI: _____

DATE COLLECTED: ____/____/____ TIME COLLECTED: ____:____ AM/PM

BILL: ☐ INSURANCE ☐ PATIENT ☐ CLIENT

PATIENT INFORMATION (PLEASE ATTACH FACE SHEET AND BACK OF PATIENT'S INSURANCE CARD)

LAST NAME		FIRST NAME		M.I.
BEST CONTACT PHONE		MEDICAL RECORD #		
DATE OF BIRTH			SEX	M F
STREET ADDRESS		CITY/STATE		ZIP
REFERRING PHYSICIAN		REFERRING NPI#	REFERRING FAX#	

CLINICAL INDICATIONS

- | | | |
|---|--|---|
| ☐ Abdominal Cramping | ☐ Constipation | ☐ Nausea |
| ☐ Anemia | ☐ Diarrhea (Bloody) | ☐ Screening Exam |
| ☐ Anorexia | ☐ Diarrhea (Watery) | ☐ Malabsorption |
| ☐ Bleeding (rectal) | ☐ Diverticulosis | ☐ Pain: _____ |
| ☐ Bleeding (GI) | ☐ Diverticulitis | ☐ Reflux |
| ☐ Blood in Stool | ☐ Dyspepsia | ☐ Vomiting |
| ☐ Change in Bowel Habits | ☐ Dysphagia | ☐ Weight Loss |
| ☐ Coffee Ground Emesis | ☐ Epigastric Pain | ☐ Other: _____ |
| ☐ Colitis Surveillance | ☐ Heartburn | |

CLINICAL HISTORY

History of Cancer

- ☐ Personal (type): _____
☐ Family (type): _____
- | | | |
|--------------------------------------|--|---|
| ☐ Barrett's | ☐ H. Pylori | ☐ Ulcer |
| ☐ Esophagitis | ☐ Reactive | ☐ Crohn's |
| ☐ Reflux | ☐ Gastropathy | ☐ Ulcerative Colitis |
| ☐ Gastritis | ☐ Celiac Duodenitis | ☐ Other: _____ |
| ☐ Polyp | | |

Notes

Notes

DIAGNOSIS CODE (PLEASE INDICATE ALL APPLICABLE)

- ☐ K3189 (Other diseases of stomach and duodenum) ☐ D122 (Benign neoplasm of ascending colon) ☐ K2950 (Unspec. chronic gastritis w/o bleeding) ☐ K317 (Polyp of stomach and duodenum)
☐ K635 (Polyp of colon) ☐ D123 (Benign neoplasm of transverse colon) ☐ D120 (Benign neoplasm of cecum) ☐ _____

Please include a copy of the endoscopy report

EXACT ANATOMIC SOURCE(S) OF TISSUE

RULE OUT CHECKBOXES

1/A	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
2/B	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
3/C	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
4/D	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
5/E	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
6/F	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
7/G	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER
8/H	Biopsy Snare Other	EE REFLUX BARRETT'S	GASTRITIS H. PYLORI SPRUE	POLYP COLITIS / IBD Mic. COLITIS	DYSPLASIA MALIGNANCY OTHER

PHYSICIAN SIGNATURE (REQUIRED FOR CMS)

PATIENT SIGNATURE

SIGNATURE: _____

SIGNATURE: _____

DATE: ____ \ ____ \ ____