



### Advanced Interventional Endoscopy

Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

\_\_\_\_ Amna Mehdi, DO      \_\_\_\_ Hazem Tabbaa, DO, MS      \_\_\_\_ Mustafa Huseini, MD  
\_\_\_\_ Erin Sattazahn, PA-C      \_\_\_\_ Zachary Landers, FNP-BC      \_\_\_\_ First Available Provider

**(Please note, if patient is established with a current GI provider, the patient will be scheduled with that provider, unless a transfer is requested.)**

Time Frame:                      \_\_\_\_ ASAP (1-2 weeks)                      \_\_\_\_ First available appointment

**(Please include most recent office visit, recent labs, DX procedures, demographic, copy of insurance card (both front and back), etc. with referral. We cannot schedule if this information is not included.)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**(Please have patient verify coverage before referring for procedure.)**

Diagnosis/Symptoms: \_\_\_\_\_

Service Requested:

\_\_\_\_ Colonoscopy    \_\_\_\_ EGD    \_\_\_\_ Colo/EGD    \_\_\_\_ Consultation    \_\_\_\_ Other    \_\_\_\_ EUS    \_\_\_\_ ERCP

Referring Physician: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

Has the patient ever seen a GI physician in the past?      \_\_\_\_ Yes      \_\_\_\_ No

If yes, who? \_\_\_\_\_ When? \_\_\_\_\_

**For Office Use Only**

Procedure/Consultation: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient Notified:      \_\_\_\_ Yes      \_\_\_\_ No