



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Patient Email: _____
Mobile Phone: _____
Home Phone: _____ Work Phone: _____

Patient agrees to receive text messages to the above mobile number for scheduling purposes

REFERRING PROVIDER

Referring Physician: _____ Date: _____
Office Phone: _____ Fax: _____
Practice / Clinic Name: _____
Address: _____

REASON FOR REFERRAL

Office Consultation Colonoscopy Upper Endoscopy (EGD) Hemorrhoid Banding

Urgency: Routine ASAP Urgent — please call (614) 927-1968

Diagnosis/Symptoms

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Abnormal Labs | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Liver Diseases |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Melena | <input type="checkbox"/> IBS | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> MASH/MASLD |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hematemesis | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatty liver |
| <input type="checkbox"/> Change in Bowels | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hematochezia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Abnormal CT scan | <input type="checkbox"/> Hospital Follow up | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Cirrhosis |

Other: _____

PLEASE SEND WITH THIS REFERRAL

- | | |
|--|--|
| <input type="checkbox"/> Copy of insurance card (front & back) | <input type="checkbox"/> Relevant office notes |
| <input type="checkbox"/> Patient demographics with updated phone number | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Prior colonoscopy / endoscopy report - Last 5 years | <input type="checkbox"/> Imaging (US, CT, MRI, etc) / Labs pertaining to diagnosis |

Please fax completed referral forms to (614) 412-2856 • Online referrals: www.codh.com • Questions: (614) 927-1968