CONSULTANTS IN GASTROENTEROLOGY, P.C.
6900 L Street, Suite 1 Lincoln, NE 68510
Phone: (402) 441-5600 Fax: (402) 441-5606

SCHEDULING FORM

Date:_____

Name: _____ Date of Birth: _____ Sex: M/F

Social Security: _____-_____-_____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Referring Physician: _____ Phone Number: _____

Requesting Procedure/Consult: _____

Reason for Exam/Consult: _____

Physician Requested: David D. Lee, MD Denise L Speich, APRN First Available

(Please provide a copy of the insurance card/s front and back, medication list, and any other pertinent information.)

Patient Weight: _____ Patient Height: _____

Prior Colonoscopy?	Y	N	If yes, date: _____
Taking blood thinners? (Coumadin/Plavix/ASA)	Y	N	
Is the patient diabetic?	Y	N	
Do they have a pacemaker or defibrillator?	Y	N	
Does the patient have kidney disease?	Y	N	
Does the patient require an interpreter?	Y	N	Which language? _____

PROCEDURE INFORMATION:

Surgeon: _____ Surgery Date: _____/_____/_____ Time: _____ Admit: _____

Procedure: _____ IV Sedation: _____ MAC: _____ LSES

R/S due to: _____ Date: _____ Time: _____ Admit: _____

Additional Comments: _____

Prep Given: Suprep Golytely Moviprep Osmoprep Miralax Other: _____

CIG Nurse: _____ Scheduler: _____ Referral: Yes No

OFFICE USE ONLY:

Appt. Date: _____ Time: _____ Provider: _____ Forms:_____ Chart?_____