TEXAS A&M PHYSICIANS

Please Fax to Brianna/Brenda
979-776-6905

COLONOSCOPY Referral Form

Brianna Clark, M.P.H. - 979-436-0443
Brenda Hernandez - 979-436-0449

Referring Physician / Organization: _____ Date: _____

Clinic: _____ Phone #: _____

Address: _____ City: _____ Fax: _____

County: _____ State: _____ Zip Code: _____

Patient Name: _____ D.O.B: _____

Mailing Address: _____ Phone #1: _____

City: _____ County: _____ State: _____ Phone #2: _____

Zip Code: _____ Patient Allergies: _____

Preferred Language: _____ Gender: Male / Female (Please Circle)

Reason for Referral: (Check all that apply)

Screening ☐ Black stools/Melena ☐ Diarrhea ☐ Anemia ☐ Bleeding ☐ Abdominal Pain ☐

Constipation ☐ Other: _____

Family History of Polyps / Colorectal Cancer: Father ☐ Mother ☐ Sibling ☐ Grandparent ☐

Comments: _____

Insurance Information: (Specify if none)

Provider: _____ Group #: _____

Policy ID #: _____ PCP: _____

Does the patient wish to determine financial assistance eligibility? Yes / No

_____ _____

Physician / PA Signature (if applicable) Date