COLONOSCOPY & ENDOSCOPY REFERRAL FORM

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

INSTITUTE FOR DIGESTIVE SURGERY

SURGEON	
❑ Dirks, Derek (MD)	❑ Richardson, Cory (MD, FACS, FASMBS)
❑ Pennings, John (MD, FACS, FASMBS)	❑ First Available

PATIENT INFORMATION					
NAME					
PHONE		**CELL**			
MAILING ADDRESS					
NEW PATIENT	❑ YES ❑ NO	**SSN**		**DOB**	
PREFERRRED METHOD OF CONTACT ❑ PHONE ❑ CELL ❑ E-MAIL					
PRIMARY INSURANCE					

REASON FOR VISIT	
COLONOSCOPY	**EGD**
❑ SCREENING	❑ GERD
❑ RECTAL BLEEDING	❑ DYSPHAGIA
❑ FAMILY HX COLON CA	❑ BLOATING
❑ PERSONAL HX COLON POLYPS	❑ HIATAL HERNIA
❑ HEMORRHOIDS	❑ EPIGASTRIC PAIN
❑ OTHER:	❑ OTHER:

CLINICAL INFORMATION	
REQUESTING ABDOMINAL ULTRASOUND	❑ YES ❑ NO
Is the patient taking any blood thinning medications?	❑ YES ❑ NO
If yes what?	
Has the patient had any prior abdominal surgery?	❑ YES ❑ NO
If yes what?	

REFERRED BY

Please fax any records related to the patient's diagnosis as well as most recent labs and EKG to
(208) 415 - 0150

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Institute for Digestive Surgery

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