Michael J. Graney, M.D. Stephen M. Rauh, M.D. Mary Lou O'Neill, M.D. Asim Farid, M.D.
Steven J. Ognibene, M.D. Bastian Domajnko, M.D. Claudia Hriesik, M.D.

Marie A. Bianchi, MSN, ACNP Barbara A. Macey, MS, NP-C, RNFA Liesl M. Hand, RPA-C
Theresa Schwartz, ANP-C Craig Durie, MSN, NP-C

LOWER ENDOSCOPY REQUEST FORM ROCHESTER COLON & RECTAL SURGEONS

DATE	TIME	PROVIDER REQUESTING EXAM:	
PATIENT NAME		**DOB:**	
(H) (WK.)	(C)	**INSURANCE:**	**REFERRAL # (*):**
SERVICE REQUESTED			
☐ COLONOSCOPY	☐ FLEXIBLE SIGMOIDOSCOPY	☐ ANOSCOPY	
☐ CONSULTATION		☐ OTHER:	
INDICATIONS:			
☐ SCREENING:		☐ RECTAL BLEEDING	
☐ asymptomatic:		☐ CHANGE IN BOWEL AND/OR PAIN	
(no changes in bowel habit, no rectal bleeding)		☐ FAMILY HISTORY OF GI NEOPLASM	
		☐ PERSONAL HISTORY OF GI NEOPLASM	
		☐ ANEMIA	
		☐ + FECAL OCCULT BLOOD	
		☐ OTHER CONCERN	
PROVIDER REQUESTED:			
☐ ANY RCRS		☐ MJG ☐ SMR ☐ MLO ☐ AF ☐ SJO ☐ BD ☐ CH ☐ MAB ☐ BAM ☐ LH ☐ TS ☐ CD	
TIMING:			
☐ ELECTIVE	☐ FIRST AVAILABLE	☐ EXPEDITED	☐ URGENT, PLS CALL US!
ALSO WITH THIS FAX (VERY HELPFUL BUT NOT REQUIRED):			
☐ PT MEDICATION LIST	☐ PT PROBLEM LIST	☐ ADDITIONAL INFO FROM REQUESTING PROVIDER	
SENDING STAFF MEMBER NAME	**PHONE**		**SIGNED**
(*) CHECK OUR WEBSITE FOR UPDATED INSURANCE INFO AS MOST PATIENTS WILL **NOT** NEED A REFERRAL NUMBER: ***ROCHESTERCOLON.COM***			
☐ please send us more service request form pads			

1255 Portland Ave, 3rd Floor
Rochester, NY 14621
Tel: (585) 266-8401
Fax: (585) 338-1477

125 Lattimore Rd, Suite 270
Rochester, NY 14620
Tel: (585) 244-5670
Fax: (585) 461-2509

121 Erie Canal Dr., Suite B
Rochester, NY 14626
Tel: (585) 225-5420
Fax: (585) 225-5505