

PATIENT INFORMATION					
Last Name		First Name		M.I.	
Street Address				Apt. #	
City			State	Zip	
Patient Phone Number			Patient Social Security Number		
Date of Birth / /	Age	Sex	Client ID #	Collection Date	

CLIENT INFORMATION	
Treating Physician	UPIN #
<b>Physician's Signature</b> X _____	

BILLING / INSURANCE (or attach copy of insurance card - both sides)			
<b>Bill:</b>	<b>Insurance</b> <input type="checkbox"/> Secondary Insurance Information Attached		
<input type="checkbox"/> Insurance	Name/Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<input type="checkbox"/> Medicare	Company Name		
<input type="checkbox"/> Medicaid	Address		
<input type="checkbox"/> Worker's Comp	City	State	Zip
<input type="checkbox"/> Patient	Employer Name		
<input type="checkbox"/> Physician	Group/Contract #	Member ID #	
<input type="checkbox"/> Hospital	Medicare #	Medicaid ID #	
<input type="checkbox"/> Other			
<input type="checkbox"/> Inpatient			
<input type="checkbox"/> Outpatient			
<input type="checkbox"/> Emergency Room			

**Send Duplicate of Report to:**

Name \_\_\_\_\_

Address/Fax \_\_\_\_\_

ESOPHAGUS / STOMACH / DUODENUM									
<b>Bottle #</b>									
<b>Biopsy</b>									
<b>Polyp</b>									
Esophagus									
Centimeter									
Cardia/Fundus									
Antral Body									
Body									
Antrum									
Duodenum 2 <sup>nd</sup>									
Duodenum 3 <sup>rd</sup>									
Other									

CLINICAL HISTORY (check all that apply)	
<input type="checkbox"/> Family HX of Cancer	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> HX of Cancer	<input type="checkbox"/> GERD
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> NSAID Usage	<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> HX of Barrett's Esophagus	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Hem Pos Stool
<input type="checkbox"/> Heartburn	<input type="checkbox"/> HX of Polyps
<input type="checkbox"/> Reflux	<input type="checkbox"/> HX Idiopathic Inflammatory Bowel Disease
<input type="checkbox"/> HX H. Pylori	<input type="checkbox"/> Other: _____

LARGE BOWEL / SMALL BOWEL									
<b>Bottle #</b>									
<b>Biopsy</b>									
<b>Polyp</b>									
Ileum									
Ileocecal valve									
Cecum									
Ascending									
Hepatic Flexure									
Transverse									
Splenic Flexure									
Descending									
Sigmoid									
Rectum									
Other									

CLINICIAN COMMENTS
_____
_____
_____
_____

LABORATORY USE ONLY	
Tech Initial	Date Rec'd
Accession #	# Spec Rec'd
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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