Huron Gastro / Center for Digestive Care / Huron Gastro Endoscopy Center

Appointment Request Form

Office: (734) 434-6262

Fax: (734) 712-2820

Date of Request: _____

Patient Name: _____ **DOB:** _____ **Gender:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

PCP / Provider Referring: _____

Reason for Visit (symptoms)**:** _____

_____

Type of Visit:

_____ **Office Visit**

_____ **Colonoscopy**

_____ **Sigmoidoscopy**

_____ **Gastroscopy/EGD**

_____ **Wellness Program/Renita:** _____

** **Please attach the following information relevant to this appointment request – Thank you!**

* **Patient Demographics w/Insurance Information**

* **Office Note(s)**

* **Medication/Allergy List**

* **Test Results – Including Lab Work and Radiology Results**

* **Endoscopy Procedures w/Pathology Results**