# Huron Gastro
# Center for Digestive Care
# 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** _____ **Gastroscopy/EGD**

_____ **Colonoscopy** _____ **Wellness Program**

_____ **Sigmoidoscopy** _____ **Dietitian Consult**

_____ **Other:** _____

** **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**