



URGENT REQUEST

ALABASTER/GRANDVIEW

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 1022 1 st St. N.
Suite 220
Alabaster, AL 35007
Phone 205-663-1023
Fax 866-813-9501 | <input type="checkbox"/> 3570 Grandview Pkwy.
Suite 200
Birmingham, AL 35243
Phone 205-663-1023
Fax 866-813-9501 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> Brian Brunson, M.D.
<input type="checkbox"/> Mohannad Dugum, M.D.
<input type="checkbox"/> John P. Day, M.D.
<input type="checkbox"/> Robert D. Loudon, M.D. | <input type="checkbox"/> Robert D. Marks, M.D.
<input type="checkbox"/> Molly McVey, M.D.
<input type="checkbox"/> Nathaniel Peyton, M.D.
<input type="checkbox"/> Bradley A. Rubery, M.D. |
|--|--|--|---|

BROOKWOOD

- | | |
|--|--|
| 513 Brookwood Blvd.
Suite 401
Birmingham, AL 35209
Phone 205-870-0256
Fax 877-342-3339 | <input type="checkbox"/> Brent N. Barranco, M.D.
<input type="checkbox"/> Gregory L. Champion, M.D.
<input type="checkbox"/> William H. Halama, III, M.D.
<input type="checkbox"/> Jim B. McPhail, M.D.
<input type="checkbox"/> Lindsay South Robison, M.D.
<input type="checkbox"/> Wiley D. Truss, M.D., MPH |
|--|--|
- FIRST AVAILABLE

PRATTVILLE

- | | |
|--|---|
| 645 McQueen Smith Rd. N
Suite 106
Prattville, AL 36066
Phone 205-870-0256
Fax 877-342-3339 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> Brent N. Barranco, M.D.
<input type="checkbox"/> Jim B. McPhail, M.D.
<input type="checkbox"/> Wiley D. Truss, M.D., MPH |
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ST. VINCENT'S EAST

- | | |
|--|---|
| 100 Pilot Medical Dr.
Suite 250
Birmingham, AL 35235
Phone 205-838-3034
Fax 877-776-2535 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> Miles E. Gresham, M.D.
<input type="checkbox"/> William C. Lopez, M.D.
<input type="checkbox"/> Rohit Malik, M.D.
<input type="checkbox"/> Robert A. Shaffer, M.D.
<input type="checkbox"/> Charles V. Welden IV, M.D. |
|--|---|

GARDENDALE

- | | |
|---|---|
| 2217 Decatur Hwy.
Gardendale, AL 35071
Phone 205-838-3034
Fax 877-776-2535 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> Miles E. Gresham, M.D.
<input type="checkbox"/> Robert A. Shaffer, M.D. |
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BLOUNT COUNTY

- | | |
|--|--|
| 150 Gilbreath Dr.
Oneonta, AL 35121
Phone 205-838-3034
Fax 877-776-2535 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> William C. Lopez, M.D.
<input type="checkbox"/> Lisa Peoples, CRNP |
|--|--|

PELL CITY

- | | |
|--|---|
| 74 Plaza Dr., Suite 1-A
Pell City, AL 35125
Phone 205-838-3034
Fax 877-776-2535 | <input type="checkbox"/> FIRST AVAILABLE
<input type="checkbox"/> Nathaniel L. Peyton, M.D.
<input type="checkbox"/> Charles V. Welden IV, M.D. |
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PATIENT INFORMATION *(please fill out or attach demo sheet)*

Patient's Name: _____ SSN: _____
 Date of Birth: _____ Sex (circle): M F
 Daytime Phone #: _____ Alternate Phone #: _____
 Insurance: _____ Referral #: _____

GENERAL GI

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Office Visit | <input type="checkbox"/> Flex Sig |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> PillCam |
| <input type="checkbox"/> EGD | <input type="checkbox"/> Hemorrhoid Banding |
| <input type="checkbox"/> Other: _____ | |

ADVANCED ENDOSCOPY - *fax requests to 877-550-1902*

- | | |
|---|---|
| <input type="checkbox"/> ERCP | <input type="checkbox"/> EUS (Endoscopic Ultrasound) |
| <input type="checkbox"/> Double Balloon Enteroscopy | <input type="checkbox"/> Esophageal/Duodenal/Colonic Stenting |
| <input type="checkbox"/> Endoscopic Mucosal Resection | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radiofrequency Ablation | |

DIAGNOSIS

- | | | | | |
|---|--|--|---|-------------------------------|
| <input type="checkbox"/> Screening | <input type="checkbox"/> Positive Hemocult | <input type="checkbox"/> Family History (Colon Cancer) | <input type="checkbox"/> Iron Deficiency Anemia | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Positive Cologuard | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Other: _____ | |

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name: _____
 Contact Name: _____ Phone: _____ Fax: _____