Endoscopy Center of Connecticut, LLC
Medical Research Center of Connecticut, LLC
Pathology Center of Connecticut, LLC
www.gastrocenter.org
(203) 281-4463 F: (203) 287-2930

Appointment Request for Residents of Extended Care Facilities / Group Homes

Please complete the following forms, attach the required medical information listed below and fax to (203-287-2930). Once we receive the completed request along with the medical records **we will call to schedule the appointment**. Unfortunately, we will be unable to schedule any appointments until all information has been received so that we may provide optimal care during the visit. Please indicate phone number ____________________and contact individual ____________________________________we should call to schedule the appointment.

Patient information

Patients Name____
DOB________Address____
Insurance Carrier_______________________________________ID #_____________________
Extended Care Facility Name and Phone (including floor extension)
____
Name and phone number of individual requesting the referral________________________
Primary Care MD____
Indication for the referral
____
____
____

Circle all that apply
Eating changes - difficulty swallowing - nausea – vomiting - wt loss
Changes in bowel habits - constipation - diarrhea - melena - rectal bleeding - last BM_____

Special Needs

Is the patient alert and oriented? Yes No
Is the patient capable of providing an accurate history? Yes No
If no, who will accompany the patient who can provide a history?
Name____Relationship____________________
Is the patient ambulatory Yes No
Is there a language barrier? Yes No
If so what is the primary language? ____

REQUIRED DOCUMENTATION

- Copy of written power of attorney, if the patient is unable to communicate, make decisions regarding their care or provide consent for treatment
- Copy of the medical record including current and past medical, surgical history
- Completed copy of the attached medication reconciliation form (attached)
- Any blood work within 60-days

____ __________________________
Signature and title of Individual completing the request Date