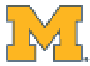

DIRECT ACCESS Capsule Endoscopy Referral
UNIVERSITY OF MICHIGAN HEALTH SYSTEM
Phone (734)998-1380
Fax: (734)232-4294

This form is available at www.med.umich.edu/gi/physician.htm

PROCEDURE REQUESTED:

☐ Video Capsule Endoscopy

PATIENT NAME: ______________________________ DOB: ____________

ADDRESS (City/State/Zip): ______________________________

Phone: ______________________________ ☐ Home ☐ Mobile ☐ Work ☐ Other

______________________________ ☐ Home ☐ Mobile ☐ Work ☐ Other

Insurance:

MRN:

REFERRING GASTROENTEROLOGIST: (REQUIRED)______________________________

ADDRESS: ______________________________

PHONE: ______________________________FAX:______________________________

PRIMARY CARE PHYSICIAN: PHONE:

DIAGNOSIS:

REASON FOR PROCEDURE:

Please fax the following records to our department for review to help expedite care:

- ☐ Most recent endoscopy reports (along with pathology reports if done)
- ☐ Recent History & Physical with medication list, Labs and other relevant records
- ☐ Recent CBC and other pertinent labs

TO SCHEDULE: FAX completed form and records to (734) 232-4294. Gut team will contact the patient.