

**CONSULTANTS IN GASTROENTEROLOGY, P.C.**  
1730 South 70<sup>th</sup> Street, Suite 110 Lincoln, NE 68506  
Phone: (402) 441-5600 Fax: (402) 441-5606

**SCHEDULING FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M/F

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Requesting Procedure/Consult: \_\_\_\_\_

Reason for Exam/Consult: \_\_\_\_\_

Physician Requested: Michael N. Eppel, MD    David D. Lee, MD    J. Reggie Thomas, D.O.    First Available

**(Please provide a copy of the insurance card/s front and back, medication list, and any other pertinent information.)**

Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_

Prior Colonoscopy?	Y	N	If yes, date: _____
Taking blood thinners? (Coumadin/Plavix/ASA)	Y	N	
Is the patient diabetic?	Y	N	
Do they have a pacemaker or defibrillator?	Y	N	
Does the patient have kidney disease?	Y	N	
Does the patient require an interpreter?	Y	N	Which language? _____

**PROCEDURE INFORMATION:**

Surgeon: \_\_\_\_\_ Surgery Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Admit: \_\_\_\_\_

Procedure: \_\_\_\_\_ IV Sedation: \_\_\_\_\_ MAC: \_\_\_\_\_ LSES / ST. E

R/S due to: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Admit: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Prep Given:    Suprep    Golytely    Moviprep    Osmoprep    Miralax    Other: \_\_\_\_\_

CIG Nurse: \_\_\_\_\_ Scheduler: \_\_\_\_\_ Referral:    Yes    No

**OFFICE USE ONLY:**

Appt. Date: \_\_\_\_\_ Time: \_\_\_\_\_ Provider: \_\_\_\_\_ Forms: \_\_\_\_\_ Chart? \_\_\_\_\_