

**GI Request**



<b>PATIENT INFORMATION</b>	Last	First	M
	SSN		
	Date of birth	Sex (circle one)	M F
	Address		
	City, State ZIP		
	Phone		

<b>PHYSICIAN INFORMATION</b>	Date
	Office site
	Ordering physician
	Primary care
	Referring
	Additional reports to (including hospitals)

ESOPHAGUS										
Specimen #	From	Biopsy				Upper Eso.			Lower Eso.	G. E. Junct.
		Brushing	Washing	Other	Upper Eso.	Lower Eso.	G. E. Junct.	Upper Eso.	Lower Eso.	G. E. Junct.
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Label specimens with patient info and tissue type submitted and place in bio-bag**

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**Please attach photocopy of patient's insurance card**

STOMACH/DUODENUM													
Specimen #	From	Biopsy				Cardia			Fundus/Body		Antrum		Duodenum
		Brushing	Washing	Other	Cardia	Fundus/Body	Antral-Body	Antrum	Duodenum	Duodenum/Small (proximal)/Bowel	Duodenum/Small (proximal)/Bowel		
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CLINICAL HISTORY (check all that apply)		
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Bleeding _____	<input type="checkbox"/> Diarrhea (Bloody)
<input type="checkbox"/> Diarrhea (Watery)	<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Family History of Cancer Type: _____	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Heme Positive Stool
<input type="checkbox"/> Hx of Barrett's Esop.	<input type="checkbox"/> Hx of H. Pylori	<input type="checkbox"/> Iron Deficient Anemia
<input type="checkbox"/> Nausea	<input type="checkbox"/> NSAID Usage	<input type="checkbox"/> Pain _____
<input type="checkbox"/> Personal History of Cancer Type: _____	<input type="checkbox"/> Personal History of Idiopathic Inflammatory Bowel Disease	<input type="checkbox"/> Personal History of Lymphoma
<input type="checkbox"/> Personal History of Polyps	<input type="checkbox"/> Reflux	<input type="checkbox"/> Weight Loss

LARGE/SMALL BOWEL																
Specimen #	From	Biopsy											Proximal		Mid	Distal
		Ileum	Ileo Cecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Other	Proximal	Mid	Distal	
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____ cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ENDOSCOPIC FINDINGS
<input type="checkbox"/> Routine Diagnosis <input type="checkbox"/> Consultation of submitted slides Total Number of Containers _____