



LANCASTER
GASTROENTEROLOGY
PROCEDURE CENTER, LLC

"EXPRESS SCHEDULING" SCREENING COLONOSCOPY FAX FORM

Fax to (717) 544-3599

Phone #: (717) 544-3500

Referred by

Provider Name _____
Provider Office _____
Provider Phone _____

Date _____

Patient Name _____ **DOB** _____

Patient's Daytime Telephone # _____

Patient Primary Insurance Company _____

Patient Secondary Insurance Company _____

Reason for colonoscopy/endoscopy _____

Form completed by _____ **Phone** _____

• Appointment Confirmation via Fax

Office / Procedure Date _____ **Time** _____

Location _____ **Provider** _____

Completed by _____ **Phone #** _____

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