

NOTE: CA TITLE 17 (SEC. 1050) REQUIRES THE PHYSICIAN TO PROVIDE PATIENT'S DOB, SOURCE OF SPECIMEN, LMP, HISTORY, THERAPY, AND SLIDE/VIAL LABELED APPROPRIATELY - TWO (2) IDENTIFIERS.

Date Collected:	Patient Name:	Birth Date:	Sex:
Street Address/Apt#:	City:	State:	Zip:
Responsible Party Phone #:	Social Security #:	MRN#	Physician Performing Procedure:

TYPE OF BILLING

COPY TO PHYSICIAN(S)

Patient Bill Insurance Medicare Client Bill
 (Please attach a copy of the front and back of the patients insurance card.)

DIAGNOSIS CODES

CLINICAL HISTORY / DIAGNOSIS

Procedure Performed:

PGQ1234567

- Colonoscopy to _____
- Flexible sigmoidoscopy to _____
- EGD with _____
- ERCP with _____
- Other _____

Indications _____

Diagnosis Codes _____

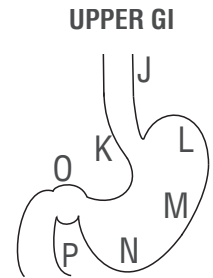
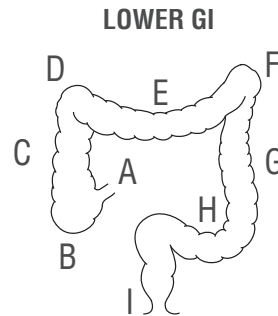
Impressions/Diagnosis _____

Occult Blood: Positive Negative Performance Check: OK Not OK

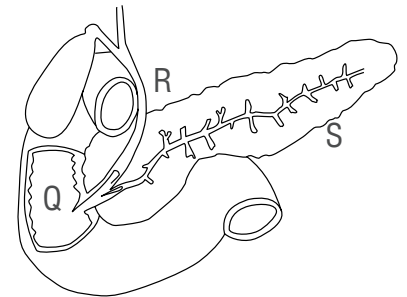
Complications: None _____

Estimated Blood Loss (none unless documented): _____

Date: _____ Time: _____ Physician Signature: _____



COMMON BILE DUCT



Bottle #	Location	Polyp	Bottle #	Location	Polyp
1			6		
2			7		
3			8		
4			9		
5			10		

Finding:

- | | | |
|----------------------|---------------------|----------------|
| Angiodysplasia | Colitis, Ulcerative | Duodenal Ulcer |
| Barretts | Colitis, Other | Esoph Varices |
| Bleeding Anal/Rectal | Crohn's Disease | Esophagitis |
| Bleeding Upper GI | Diverticulosis | Gastritis |
| Cancer, Type _____ | Duodenitis | Polyps _____ |
| Other _____ | | |

Pt. Name: _____ Source: _____ PGQ1234567	Pt. Name: _____ Source: _____ PGQ1234567	Pt. Name: _____ Source: _____ PGQ1234567	Pt. Name: _____ Source: _____ PGQ1234567
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