Pezzone Gastroenterology Associates P.C.

Michael A. Pezzone, M.D., Ph.D., A.G.A.F.

86 Wellness Way Washington, PA 15301

Phone: 724-503-4637 Fax: 724-503-4429 (drpezzone.com)

Procedure and Office Referral Form

Patient Information:

Patient name:_____ Phone:_____

DOB:_____

Address:_____

Insurance Name: _____ID: _____

Request: (please circle)

Colonoscopy Upper Endoscopy Office Consult

Reason for your referral (diagnosis):_____

We perform procedures at the following locations and days:
(please circle one if ordering a procedure)

Washington Hospital	St. Clair Hospital	UPMC South Surgery	Peter Twp Surgery Ctr.
155 Wilson Ave	1000 Bower Hill Rd	1300 Oxford Drive	160 Gallery Drive, Suite 600
Washington, PA15301	Pittsburgh, PA 15243	Bethel Park, PA 15102	McMurray, PA 15317
Mon /Wed /Thurs	Wed	Fri	Tues /Fri

Referring Information:

Referring Doctor:_____ Phone: _____
Address: _____ Fax: _____

Colonoscopy prep information will be mailed or phoned into the above listed pharmacy. New Patient forms and all prep information is also located on our website at drpezzone.com. Patients on blood thinning medications will need to stop 3-5 days prior to procedures.

FAX: 724-503-4429