Washington University in St. Louis Physicians

Welcome!

Washington University Colon and Rectal Surgery Contact Sheet

Patient Name _____ Date_____ /_____ / _____

Please fill in the information below so that we may send medical correspondence to the following:

REFERRING PHYSICIAN

Physician Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

PRIMARY CARE PHYSICIAN

Physician Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

GASTROENTEROLOGIST

Physician Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

OTHER CONTACTS

Please list other contacts (family member, friend) with whom we may discuss your care.

Name _____ Relationship to You _____

Best Phone _____ ☐ home ☐ work ☐ cell

Other Phone _____ ☐ home ☐ work ☐ cell

Name _____ Relationship to You _____

Best Phone _____ ☐ home ☐ work ☐ cell

Other Phone _____ ☐ home ☐ work ☐ cell

This form is confidential and will become part of the patient's medical record.