

**CoCoPATH**

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GASTROINTESTINAL PATHOLOGY

CONTRA COSTA PATHOLOGY ASSOCIATES

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PATIENT INFORMATION				
REQUIRED	Last Name	First Name	COLLECTION DATE	
	Date of Birth		[] Male [] Female	
	Address			
	City		State	Zip
	Home Number ()	Work Number ()	PHYSICIAN OFFICE INFORMATION	
BILLING		ATTACH BOTH SIDES OF ALL INSURANCE CARDS		
DIAGNOSIS		ICD10: _____		
		COPIES TO: NAME / FAX		
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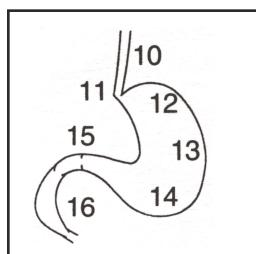
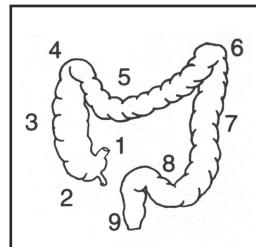
PROCEDURE PERFORMED:

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

INDICATIONS: _____

ICD 10 CODE: _____

IMPRESSIONS / DIAGNOSIS:

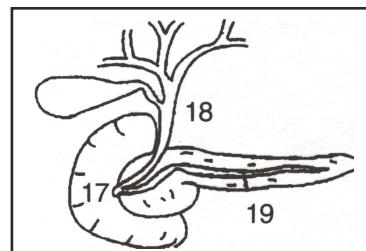


OCCULT BLOOD: Positive Negative PERFORMANCE CHECK: OK Not OK

COMPLICATIONS: None _____

Estimated Blood Loss (none unless documented): _____

Date: _____ Time: _____ Physician Signature: _____



FINDINGS:

BOTTLE #	LOCATION	BOTTLE #	LOCATION
A		G	
B		H	
C		I	
D		J	
E		K	
F		L	

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 _____		