GI PATIENT REFERRAL FORM

Date: _____ Would you like us to contact the patient? ☐Yes ☐ No

REFERRING MD: _____ Phone:_____

Patient's Name: _____ DOB:_____

Patient's Insurance Type: ☐ HMO ☐ PPO ☐ POS ☐ Medicare ☐ Open Access

Patient's Insurance Provider_____ Subscriber ID_____

Patient Phone Number: _____

Dx./Reason:

_____

PRIORITY: ☐ Urgent (**<**72 hours) ☐ Routine (<2 weeks)

SPECIAL CONCERNS:

☐Sleep apnea ☐CHF ☐Diabetes ☐Renal insufficiency ☐Hx coronary valvular disease

☐Difficult sedation/High tolerance ☐On ASA/Coumadin/Plavix/Lovenox (please circle)

SERVICE REQUESTED:

- ☐ **Consultation Only**

Consultation with

- ☐ **EGD**
- ☐ **Colonoscopy**
- ☐ **ERCP**
- ☐ **Capsule Endoscopy**
- ☐ **Bravo**
- ☐ **PEG Tube**

In the interest of providing the best possible care to your patient and to avoid expensive duplication of tests; kindly fax the following documents to our office:

- **All recent Labs (CBC, Chemistry, etc.)**
- **All Liver Tests (Hep A, B, C, etc.)**
- **All Radiological exams (CT scan, ultrasounds, MRIs, GI x-rays, etc.)**
- **Recent Progress Notes**
- **Medication List**

Please Fax to (562) 426-2862 and we will arrange appointment
We will respond within 24 hours with confirmation
****IF URGENT PLEASE CALL OUR OFFICE AT (562) 595-5421****