Innovative, personalized care for your digestive health

GI Referral Worksheet

Referring Physician: ______________________ Clinic Name: ____________________________

Referring NPI#: ____________________ Contact Name: __________________________

Phone: (____) ______________________ Fax: (____) ______________________________

Reason for referral (please circle one or the other): ***Screening Colonoscopy*** *or*

Specific Condition: ____

Patient Name: ______________________________________

Contact Person/Patient Representative: __________________________________

DOB: _______________________ Social Security #: ________________________

Phone: Home: (_____) _______________ Work: (_____) _______________

Cell: (_____) _________________ Other: (_____) _______________

Address: ____

City: ________________________ State: ___________ Zip: _____________

* *

PLEASE FAX:

* Insurance Card and Demographics
* Chart Notes
* Labs
* CT scan, Ultra Sound, etc…
* Any and all tests or procedures pertaining to diagnosis

* *

Please complete this section if physician referral is required.

Insurance Information: ____

Referral Number: ____________________ Dates Valid: ______________________________

Number of visits covered: ______________ Procedures covered: ______________________