

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****