

**Gastroenterology Referral Care Request**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_ REQUESTING PROVIDER: \_\_\_\_\_

STAFF CONTACT NAME/PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

**Please attach copies of demographic and insurance information with this form**

CONSULTATION NEEDED:

Please provide consultation and appropriate treatment. Patient has the following diagnosis/symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROCEDURE NEEDED:

\_\_\_\_\_ Please schedule patient for a screening colonoscopy.  
A no-charge pre-procedure visit will be scheduled prior to the procedure.

\_\_\_\_\_ Please schedule patient for the following diagnostic procedure(s) only and return to my practice for management and follow up. A no-charge pre-procedure visit will be scheduled prior to the procedure as appropriate.

\_\_\_\_\_ Colonoscopy    \_\_\_\_\_ EGD/Colonoscopy    \_\_\_\_\_ Endoscopy    \_\_\_\_\_ Flexible Sigmoidoscopy

Patient has the following procedure related diagnosis/symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For all patients with acute/chronic diagnosis or symptoms, please fax recent office notes with the patient's medications, labs, x-rays, GI related reports for all patients with diagnosis or symptoms.**

We will contact your patient the same or next day after receiving your referral request and will schedule your patient with the first available provider. We will notify you if we are unable to reach the patient or if the patient cancels and does not reschedule or does not show up for the appointment.

If you would like the patient to see a specific provider, please list preferred provider(s) name below:

\_\_\_\_\_