

Athens Gastroenterology Center

G.I. PATIENT REFERRAL FORM

If your office has recently made a referral to Dr. Smith, please complete this form and fax it to our office at (706) 548-0555, along with the requested information.

Name of Patient: _____

Date of Birth: _____ Phone: _____

INSURANCE INFORMATION

Please complete below, or fax demographic sheet.

Name of Insurer: _____

Group No.: _____ Policy ID No.: _____

Is this patient an HMO patient? Yes No

If yes, have you obtained a referral from the PCP? Yes No

If yes, fax the referral sheet along with the requested information. If no, please obtain one from the patient's PCP.

PATIENT ALLERGIES

PRIORITY LEVEL

ASAP As Appropriate Non-Urgent

REASON FOR REFERRAL

Please check all that apply: Colon Screening Colonoscopy Gastroscopy

Dilatation Flexible Sigmoidoscopy Esophageal Manometry ERCP

Dysphagia Irritable Bowel Syndrome GERD

Rectal Bleeding (describe amount and color): _____

Other reason for referral: _____

Does the patient have any recent lab work? Yes (please send copies) No

Have any of the following tests been performed? CT MRI Small Bowel Series

Upper/Lower GI Other: _____

If yes, please send copies. Please send any abnormal lab work or test.

REFERRING MD

PCP: _____ Date: _____

Contact Person: _____ Phone: _____