



*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: \_\_\_\_\_

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**PLEASE FAX:**

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

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*Please complete this section if physician referral is required.*

Insurance Information: \_\_\_\_\_

Referral Number: \_\_\_\_\_ Dates Valid: \_\_\_\_\_

Number of visits covered: \_\_\_\_\_ Procedures covered: \_\_\_\_\_