Digestive Health Specialists, P.A.

Colon Cancer Prevention Center

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www.digestivehealth.ws

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 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:

_____