Digestive Health Specialists, P.A.

Caring for You, Close to Home.

336.768.6211 | 336.768.6869 FAX | WWW.DIGESTIVEHEALTH.WS

Gastroenterology Referral Care Request

Patient Name: _____ Patient Date of Birth: _____

Primary / Day time phone number(s): _____

Referring Practice Name AND Provider: _____

Referring Staff Contact Name / Phone number: _____

Please attach copies of demographic and insurance information with this form. NOT REQUIRED IF PATIENT HAS AN EPIC MRN.

Consultation Needed:

Yes _____ Diagnosis: _____

Location (circle preferred): Advance Kernersville King Thomasville Winston-Salem

First Available: _____ Preferred provider: _____

Procedure Needed:

Colonoscopy _____ Diagnosis: _____

Endoscopy/Colonoscopy _____ Endoscopy: _____

Diagnosis/symptoms: _____

_____

Location (circle preferred): Advance Kernersville King Thomasville Winston-Salem

First Available: _____ Preferred provider: _____

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. NOT NEEDED IF INFORMATION IS IN PATIENT'S EPIC RECORD.

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.