

REFERRING PHYSICIAN'S INFORMATION SHEET

PATIENT NAME: _____ DOB: _____

PATIENT PHONE#: _____ ALTERNATE PHONE#: _____

**REFERRING
PHYSICIAN:** _____

PHYSICIAN PHONE# _____

DIAGNOSIS/REASON FOR CONSULT: _____

PRIMARY INS: _____ POLICY#: _____

SECONDARY INS: _____ POLICY#: _____

GI CONSULT

Needs evaluation and screening
Colonoscopy

Needs evaluation and EGD

FOLLOW UP GI VISIT

Existing patient who needs a followup
Appointment
