GASTROENTEROLOGY REFERRAL FORM

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For your convenience, please complete this form and fax back to us at 706-548-0555, along with the relevant information. This is to help us better serve you and your patient. We will contact the patient and fax this sheet back to you with the date/ time within 24 business hours. For questions/ concerns, contact us at 706-548-0058. Thank you for your referral.

RERFERRING PHYSICIAN INFORMATION:

Referring Physician:	Contact Person:	Phone: Fax:

PATIENT GENERAL INFORMATION:

Patient Name:		DOB:	SSN:
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Gender (circle one): Male Female Transgender (If transgender, please also circle previous sex.)		PCP (if known):	**Today's Date:**

INSURANCE INFORMATION: (Please fax copy of insurance card front and back side.)

Primary Insurance:	ID#:	Group#:
Secondary Insurance:	ID#:	Group#:

*If patient's insurance requires a referral, **please attach**. This referral will need to have an authorization number from the insurance company.*

MEDICAL INFORATION:

Priority Level (Circle): Urgent Non-Urgent	Diagnosis:	Patient prefers (Circle): AM PM Days: M T W Th F
Hemoccult test done? (Circle): Yes No	Hemoccult results? (Circle if applicable): Positive Negative	

*Please be sure to fax any medical records pertaining to the reason for visit, such as:
Last office note, recent lab results, GI X-Rays, Endoscopy Reports, GI Pathology Reports, and patient's insurance card.*

Also, please inform the patient their initial visit is an OFFICE CONSULTATION ONLY. They will need to bring a list of all medications they are currently taking, their insurance card, and come in five minutes early for their appointment to fill out paperwork.

This box below is for Athens Gastroenterology Center use only: We will fax over appointment date and time.

APPOINTMENT DATE:_____ APPOINTMENT TIME:_____ PROVIDER: _____

Thank you for your referral. We will contact the patient to give them the appointment information.

Rv 04.23.2012kg