GASTROENTEROLOGY & ADVANCED ENDOSCOPY REFERRAL FORM

PATIENT____ DOB _____________________ ☐ MALE ☐ FEMALE

HOME PHONE ________________ MOBILE PHONE ___________________ EMAIL ________________________

ORDERING PROVIDER ______________________________________ CONTACT PHONE ___________________

DIAGNOSIS____

INSURANCE _____________________________________ ID ________________ AUTH #___________________

PROCEDURE REQUESTED (Please check all that apply):

☐ EUS (☐ WITH FNA)
☐ ERCP
☐ SPYGLASS CHOLANGIOSCOPY
☐ BALLOON ENTEROSCOPY
☐ RADIO FREQUENCY ABLATION (RFA)
☐ ENDOSCOPIC MUCOSAL RESECTION
☐ CRYOABLATION
☐ ENDOLUMINAL STENTING
☐ CONSULTATION
☐ OTHER ____

WORKUP DONE (Please check all that apply): ☐ ENDOSCOPY ☐ CT / MRI ☐ BIOPSY

WHEN TO SCHEDULE (Please check one):
☐ URGENT (MD TO MD CALL REQUIRED)
☐ ASAP
☐ NEXT AVAILABLE

PREFERRED PHYSICIAN, IF ANY : ____

WOULD PROVIDER PREFER CALL BACK? (Check One):
☐ AFTER INITIAL CONSULT
☐ AFTER PROCEDURE
☐ NEITHER, JUST FAX BACK REPORTS TO FAX NUMBER: _______________________________

SPECIAL INSTRUCTIONS:____

PLEASE RETURN THIS COMPLETED FORM AND ATTACH ALL REPORTS WITH PROVIDER CLINICAL NOTES TO:

FAX
(480) 507-5677

2680 S Val Vista Dr, Suite 116 • Gilbert, AZ 85295 • Phone (480) 507-5678

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