Regional Digestive Consultants

Referral Form

Please complete this form and fax with the PATIENT'S LAST OFFICE VISITS, ALL RECENT LAB AND X-RAY RESULTS, ANY PREVIOUS COLON/EGD REPORTS and PATHOLOGY, COPIES OF INSURANCE CARDS. IF YOU ARE REFERRING THIS PATIENT FOR A SCREENING COLONOSCOPY, please be aware that all insurance plans do not cover this, and Pt needs to be at least 50 years of age. **PATIENT NEEDS TO BRING INSURANCE CARDS AND LIST OF MEDICATIONS TO THEIR APPOINTMENT.**

Referring MD: PH #:

Fax #: Email:

PATIENT'S NAME: DOB:

HM PH#: WR PH#:

CELL PH#: Email:

**APPOINTMENT REQUESTED **

OFFICE CONSULT and DX:

COLONOSCOPY and DX:

EGD and DX:

Small Bowel capsule:

ESOPHAGEAL MANOMETRY AND PH Testing:

Physician Requested_____ Can your patient see 1st available physician Assistant ◯Yes ◯No

Which office? WDLS/HUMBLE/CYPRESS STATION

We will contact your patient and schedule the appointment:

** Please Fax pertinent medical records to 281-419-8485. **

Call if you have any questions: Ph # 281-528-1511.

SUBMIT