



Digestive Health Specialists

OF THE SOUTHEAST

REFERRAL FORM

Date: _____ Referring Physician: _____

Referring Physician Phone: _____ Fax: _____

PATIENT INFORMATION

Name _____ DOB _____ M or F

Address _____

Telephone Number Home _____ Work/Cell/Alt _____

SSN _____ Insurance Carrier _____

Insured Name (self/spouse) _____ DOB _____

Contract/Policy No. _____ Group No. _____

REFERRAL INFORMATION

This patient is being referred for:

_____ Colonoscopy

_____ EGD

_____ Office Visit

Reason: _____

Indication: (please mark all that apply)

Screening

Dyspepsia

Diverticulosis

Blood in Stool

Anemia

Gastritis

Reflux

Abdominal Pain

Diarrhea

Dysphagia

Esophagitis

Hemorrhage of GI Tract

Constipation

Personal Hx of Polyps

Family Hx of Colon Ca

**PLEASE FAX THIS FORM TO US AT 836-1888. WE WILL CALL THE
PATIENT AND SET UP THE REQUESTED APPOINTMENT.**

THANK YOU.

OFFICE USE ONLY – DO NOT WRITE IN THIS AREA

Appt Date _____ Appt Time _____

w/Dr. _____ Facility _____