Referral Form

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Please fax all relevant documents required for patient care including labs, imaging, medication list, etc.

Patient Information:

Name: _____

DOB: _____ Phone: _____

Address: _____City/State/Zip: _____

Primary Insurance: _____
ID/Policy: _____ Group: _____

Secondary Insurance: _____
ID/Policy: _____ Group: _____

(If Medicaid is primary, be sure to send a Medicaid referral from primary doctor listed with Medicaid)

Referring Doctor/APN: _____

Address:_____

Phone:_____ Fax: _____

Clinic Contact: _____ Date: _____

Please circle what is being ordered: Office Visit Colonoscopy EGD

Related Diagnosis(s) : _____

Is the patient taking any blood thinners? Yes No If yes, please circle below

Eliquis (apixaban)- Plavix(clopidogrel)- Xarelto (rivaroxaban)- Brilinta (Ticagrelor)- Pradaxa (dabigatran)-

Effient (Prasugrel)- Coumadin (warfarin)- Aggrenox (ASA and dipyridamole)

Name of patient's cardiologist _____

Is the patient taking diet pills or injections? Yes No Which one:_____