CULLMAN REGIONAL | Colon & Gastro

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GASTROENTEROLOGY/HEPATOLOGY REFERRAL FORM

Patient's Name: _____

DOB: _____ Email: _____ Cell #: _____

Address: _____

Insurance Carrier: _____

Policy #: _____

Referral authorization # *(if required)* _____

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

PATIENT IS BEING REFERRED FOR:

- ❑ Abdominal Pain
- ❑ Anemias
- ❑ Barrett's Surveillance/Ablation
- ❑ Blood in Stool
- ❑ Celiac Disease
- ❑ Chronic Diarrhea
- ❑ Cirrhosis
- ❑ Constipation
- ❑ Dysphagia (trouble swallowing)
- ❑ Elevated LFTs
- ❑ Endoscopy/Advanced Endoscopy
- ❑ Enteroscopy
- ❑ Eosinophilic Esophagitis (EOE)
- ❑ ERCP
- ❑ Family Hx of Colon Cancer
- ❑ Fatty Liver/MASH
- ❑ Gastritis
- ❑ GERD (heartburn)
- ❑ Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Pancreatic Disease
- ❑ Screening Colonoscopy
- ❑ Small Bowel Capsule Endoscopy
- ❑ Weight Loss

❑ Other: _____

ORDERING PROVIDER:

Physician: _____

Phone: _____ Fax: _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures.