

**UHC GASTROENTEROLOGY**

681.342.3690 PHONE | 527 MEDICAL PARK DRIVE, SUITE 402  
681.342.3695 FAX | BRIDGEPORT, WV 26330

**Appointment Referral Form**

**GASTROENTEROLOGY**

**\*Please complete form, fax to 681-342-3695 and advise your patient that our office will be calling them with appointment date and time**

**Referral Date:** \_\_\_\_\_ **Referring Provider:** \_\_\_\_\_

**Staff Name:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Primary and Secondary Ins:** \_\_\_\_\_ **M or F**

**\*Can the patient make their own medical decisions and sign medical consents? Yes No**  
**(If NO, a legal representative, guardian or medical power of attorney MUST accompany the patient and provide all legal documents)**

**\*Does this patient's insurance require an authorization to see a specialist? Yes No**

**Authorization Information:** \_\_\_\_\_

**Reason for referral:** \_\_\_\_\_  
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**Physician Preference:** \_\_\_\_\_ **or 1<sup>st</sup> Available:** \_\_\_\_\_

**Please Note:**

- Please include most recent progress notes, lab results, pathology reports, CT reports, and procedure reports.
- Please include any additional information pertinent to this referral.
- We will notify the patient by mail and phone of appointment time and date.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Update: 6/27/2019

**Office Use Only:** **E#:** \_\_\_\_\_ **Appt. Date & Time:** \_\_\_\_\_