Center for Digestive Diseases and Cary Endoscopy Center
Referral/Consultation Request Form
Phone: 919-854-0041 Fax: 919-854-0049

Referring Provider: _____Practice Name: _____

Contact Person:_____Phone_____

Patient Name: _____ DOB: _____

Sex: M F

Contact Numbers: Cell: _____ Other: _____

Address:_____
_____

We participate in most major health insurance plans; <u>PLEASE VERIFY WE PARTICIPATE WITH YOUR PATIENT'S INSURANCE</u>

Insurance(s) _____ID# _____

Group# _____ Policy Holder _____

DOB _____

<u>Open Access for GI procedure without per-procedure consultation (Direct – No Office Visit):</u> (essentially asymptomatic patients)
___ Colonoscopy for routine screening; family history; hem + stool; intermittent BRBPR
___ EGD for Barrett's screening in patient with well controlled GERD

<u>Consultation Requested (Office Visit)</u>:

EGD/Colonoscopy (circle procedure requested)

Reason for Visit:_____
_____

*****PLEASE FORWARD RECENT LABS, RADIOLOGY, PROCEDURES, OFFICE NOTE, MEDICATION LIST, COPY OF INSURANCE CARD TO 919-854-0049 WITH THIS FORM*****

Appointment Date: _____ Time: _____

With Dr. _____