Kalamazoo Gastroenterology Hepatology Digestive Health Center

Telephone: 269-385-9900 Fax: 269-385-2140 or 269-385-4873

Referral Form

☐ **Urgent** ☐ **Routine**

Referring Provider: _____ Date:_____

*Supervising Physician: _____ *If referring provider is a PA, please include the name of the supervising physician

Referring Office Contact Person: _____

Telephone: _____ Fax: _____

ATTACH THE FOLLOWING REQUIRED RECORDS WITH REFERRAL:

☐ Allergies ☐ Demographic Sheet ☐ Insurance Cards (front and back) ☐ Lab/Cultures ☐ Pathology

☐ Medication List ☐ Office Notes/Dictation ☐ Past Medical History ☐ Colonoscopy/EGD Reports

Radiology: ☐ CT ☐ Bone Scan ☐ MRI ☐ PET Scan ☐ X Ray ☐ Other _____

PATIENT INFORMATION:

First:	MI:	Last:		Pref:
DOB:	☐M ☐F SSN:		Home:	☐
Address:			Day:	☐
City:	State:	Zip:	Cell:	☐
Email:				
Interpreter/Language:		PCP:		

INSURANCE INFORMATION: ***Please attach front and back copy of insurance card(s)***

Primary:	Policy ID:	Group :
Policy Holder:	DOB:	Relationship to Patient:
Secondary:	Policy ID:	Group:
Policy Holder:	DOB:	Relationship to Patient:

REFERRAL INFORMATION:

☐ Consult	☐ Colonoscopy	☐ EGD	☐Other _____		
Referral Reason/Symptoms:					
Appt. Preference:	☐ AM	☐ PM	☐ Other _____		
☐ 1st Available	☐ Dr. Dewan	☐ Dr. Beyer	☐ Dr. Locovei	☐ Dr. Turk	☐ Dr. Sharma

Revised 09/07/2017