PATIENT REFERRAL FORM

FAX YOUR REFERRALS TO 616-956-6637

DATE ______________________________

REFERRED TO (circle one): **Colonoscopy or Endoscopy** **General Surgery** **Weight Loss**

Please NOTE: Patients must weigh *less than 500lbs* and *NOT be wheelchair-bound* for a colonoscopy or endoscopy.

PATIENT INFORMATION

Patient's First Name ______________________

Last Name ______________________

DOB___/___/___ Gender: Male ❑ Female ❑

Address ______________________

____

Daytime Phone (______) ______________________

Alternate Phone (______) ______________________

MEDICAL INFORMATION

Diagnosis/Reason for referral ______________________

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Patient's Height ________ Weight ______________

AND/OR

Patient's BMI ______________________

Would you like to be notified when appointment is scheduled? Yes❑ No❑

Contact Method: ______________________

INSURANCE INFORMATION

Some insurance plans require prior authorization obtained by the PCP. Please verify with insurance

Health Plan ______________________

Member ID ______________________

Group # ______________________

*Authorization # ______________________

Secondary Insurance, if any ______________________

REFERRING DOCTOR CONTACT INFORMATION

Name ______________________

Phone (______) ______________________

Fax (______) ______________________

Office Name ______________________

ATTACHMENTS

❑ Pertinent Medical/Operative Notes (*If referring patient for a colonoscopy please include prior colonoscopy procedure note and any biopsy results*.)

❑ Pertinent Lab Studies

❑ Documentation of Previous Weight Loss Attempts