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:	
	· · · · · · · · · · · · · · · · · · ·
Insurance(s)	ID#
Group#	Policy Holder
DOB	
Visit): (essentially asympton Colonoscopy for routine	natic patients) screening; family history; hem + stool; intermittent BRBPR
Consultation Requested (O	
EGD/Colonoscopy (circle pr	ocedure requested)
Reason for Visit:	I procedure without per-procedure consultation (Direct – No Office asymptomatic patients) r routine screening; family history; hem + stool; intermittent BRBPR 's screening in patient with well controlled GERD ested (Office Visit): (circle procedure requested) RWARD RECENT LABS, RADIOLOGY, PROCEDURES, OFFICE TION LIST, COPY OF INSURANCE CARD TO 919-854-0049 WITH THIS FORM***
	IST, COPY OF INSURANCE CARD TO 919-854-0049 WITI
Appointment Date:	Time:
With Dr	