REFERRAL FORM

CENTRAL INDIANA GASTROENTEROLOGY GROUP

PLEASE REFER TO: (Please check one) **(GI Office Use: Last DOS:_______ MR#:_________)**

____ Chris Foster, MD ____ Jon Maier, MD ____ Rod Nisi, MD ____ Thomas Nowak, MD ____ 1st Available

Date of Referral ___________________ Ref. Physician ___________________ NPI # _________________

Ref. Phone # ____

Ref. Fax # ______________________ Caller _________________

PCP ___________________ PCP Phone # ___________________ Hosp. Preference _____________________

Patient's Full Legal Name: ______________________________________ Pt. Goes By: __________________

Address: ____ City:________________________ State: ___

Zip: ________ Home Phone: ______________________ Work/Cell Phone: _________________ Ext: ____

Date of Birth: ___________________ SS #: ____________________________

Insurance: _________________________________ Subscriber: _____________________ DOB: __________

Policy #: __________________________ Group #: _______________________ Phone #: _______________

FAX COPY (FRONT/BACK) of INSURANCE CARD w/REFERRAL in order to SCHEDULE the PATIENT

******All pertinent testing, labs, x-rays* *MUST*** **be received with the referral in order to schedule patient. PLEASE fax to: (765) 649-0014. Our scheduling department will contact the patient within 48 hours of receiving the completed referral with all of the requested information. Thank you.**

Phone: (765) 646-8477 **Fax:(765) 649-0014**

(Check all that apply)

Diagnosis: **___Anemia (need Labs) ____Diarrhea ___Constipation ___Black Stools/Melena**

____Bleeding/Lower ___Abdominal Pain ___Epigastric Pain ___Nausea ___Vomiting

____GERD ____Hepatitis ____Pers. Hx of Colon Polyps/ CA ____ Fam. Hx Colon Polyps/ CA

____Screening Colonoscopy/ No Symptoms ____Other:______________________________

Date: _______________________ Time: ________________________

Location of Procedure: ________________________ Office Visit: ________________________

Called pt:____