GASTRO HEALTH

PATIENT REFERRAL FORM

☐ URGENT REQUEST

ALABASTER/GRANDVIEW

☐ FIRST AVAILABLE

☐ 1022 1st St. N.
Suite 220
Alabaster, AL 35007
Phone 205-663-1023
Fax 866-813-9501

☐ 3570 Grandview Pkwy.
Suite 200
Birmingham, AL 35243
Phone 205-663-1023
Fax 866-813-9501

☐ Brian A. Brunson, M.D.
☐ John P. Day, M.D.
☐ Mohannad Dugum, M.D.
☐ Robert D. Loudon, M.D.
☐ Robert D. Marks, M.D., MPH
☐ Molly McVey, M.D.
☐ Nathaniel Peyton, M.D.
☐ Bradley A. Rubery, M.D.

☐ BROOKWOOD

513 Brookwood Blvd.
Suite 401
Birmingham, AL 35209
Phone 205-870-0256
Fax 877-342-3339

☐ FIRST AVAILABLE
☐ Brent N. Barranco, M.D.
☐ Gregory L. Champion, M.D.
☐ William H. Halama, III, M.D.
☐ Lindsay South Robison, M.D.
☐ Wiley D. Truss, M.D., MPH

☐ PRATTVILLE

645 McQueen Smith Rd. N
Suite 106
Prattville, AL 36066
Phone 205-870-0256
Fax 877-342-3339

☐ FIRST AVAILABLE
☐ Brent N. Barranco, M.D.
☐ Faris H. Pacha, D.O.
☐ Wiley D. Truss, M.D., MPH

☐ ST. VINCENT'S EAST

100 Pilot Medical Dr.
Suite 250
Birmingham, AL 35235
Phone 205-838-3034
Fax 877-776-2535

☐ FIRST AVAILABLE
☐ Miles E. Gresham, M.D.
☐ William C. Lopez, M.D.
☐ Faris H. Pacha, D.O.
☐ Rohit Malik, M.D.
☐ Robert A. Shaffer, M.D.
☐ Charles V. Welden IV, M.D.

☐ GARDENDALE

2217 Decatur Hwy.
Gardendale, AL 35071
Phone 205-838-3034
Fax 877-776-2535

☐ FIRST AVAILABLE
☐ Miles E. Gresham, M.D.
☐ Robert A. Shaffer, M.D.

☐ BLOUNT COUNTY

150 Gilbreath Dr.
Oneonta, AL 35121 Phone
205-838-3034
Fax 877-776-2535

☐ FIRST AVAILABLE
☐ William C. Lopez, M.D.
☐ Lisa Peoples, CRNP

☐ PELL CITY

74 Plaza Dr., Suite 1-A
Pell City, AL 35125
Phone 205-838-3034
Fax 877-776-2535

☐ FIRST AVAILABLE
☐ William Lopez, M.D.
☐ Charles V. Welden IV, M.D.

PATIENT INFORMATION *(please fill out or attach demo sheet)*

Patient's Name: _____ SSN: _____

Date of Birth: _____ Sex (circle): M F

Daytime Phone #: _____ Alternate Phone #: _____

Insurance: _____ Referral #: _____

PROCEDURE REQUESTED

☐ Office Visit ☐ Colonoscopy ☐ EGD ☐ Flex Sig (FSI) ☐ Pill Cam

☐ ERCP ☐ Double Balloon Endoscopy ☐ Hemorrhoid Banding ☐ EUS (Endo Ultrasound)

DIAGNOSIS

☐ Screening ☐ Positive Hemoccult ☐ Family History (Colon Cancer) ☐ Iron Deficiency Anemia ☐ GERD

☐ Positive Cologuard ☐ Abdominal Pain ☐ Rectal Bleeding ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name: _____

Contact Name: _____ Phone #: _____ Fax: _____