GASTRO HEALTH

GASTRO HEALTH - SPRINGFIELD REFERRAL

Patient Name: _____ Date of Birth: _____ Date: _____

Home Phone Number: _____ Cell Phone Number: _____

Referring Provider: _____

Fax: _____ Phone: _____ Completed By: _____

Reason for Referral

- ☐ Change in Bowel Habit
- ☐ Constipation
- ☐ Diarrhea
- ☐ GI Bleed
- ☐ Rectal Bleed
- ☐ Anemia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ NASH/NAFLD
- ☐ Weight-Loss
- ☐ Liver Lesion/Mass
- ☐ Abdominal Pain
- ☐ GERD/Heart Burn
- ☐ Non-Cardiac Chest Pain
- ☐ Abnormal LFTs
- ☐ Consult
- ☐ Other: _____
- ☐ EGD: _____
- ☐ Screening Colonoscopy: _____
- ☐ Diagnostic Colonoscopy: _____

Along with this referral form, the following items are needed before the referral can be completely processed:

Insurance Information
Demographic Information
Diagnostic Testing Reports *(MRI/CT Scan, X-Ray, Previous GI Procedures, Previous Labs)*
Most Recent Office Note Including Health History & Medication List

Patient Needs to be Seen: ☐ ***ASAP*** ☐ ***Within One Week*** ☐ ***Next Available***

GASTRO HEALTH - SPRINGFIELD TEAM ONLY

Appt. Date: _____ Appt. Time: _____ Scheduler: _____

Date Faxed to Referring Provider: _____ PCP Letter: _____

Attempt 1: _____ Attempt 2: _____

2355 Derr Rd., Suite A, Springfield, OH 45503 • Phone 937-629-0100 • Fax 937-629-3285 • GastroHealth.com/Springfield