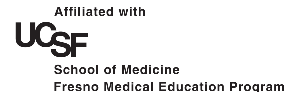
FAX REFERRAL REQUEST

University | Gastroenterology & Hepatology Associates



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Date: ______________________ Number of Pages: ______________________

☐ *Marina Roytman, M.D.*
Hepatology

☐ *Thimmaiah Theethira, M.D.*
IM/GI

REQUIRED PATIENT INFORMATION

- ☐ Demographics/Insurance
- ☐ Procedure Report(s) (EGD, Colon, EUS, etc.)
- ☐ Imaging/Scans (CT, MRI, US)
- ☐ Labs
- ☐ Pathology

- ☐ Inflammatory Bowel Disease
- ☐ Second Opinion

*****NOTE: All information is needed to schedule an appointment.

Referring Physician: ______________________ Phone: ______________________

PCP (if different from referring): ______________________

Patient Name: ______________________ DOB: ______________________

Patient Home Phone: ______________ Cell: ______________ Work: ______________

Consultation For: ______________________

Diagnosis (required):______________________

Is the Patient Pregnant? (☐ YES ☐ NO) ______________________

Contact Person: ______________________ Title: ______________________

Phone: ______________________ Fax: ______________________

Thank you very much for referring your patient to our office!

02.12.2019