REFERRAL REQUEST

FAX TO: (336) 765-2869
PHONE: (336) 448-2427 *(Option 1)*

REFERRING PROVIDER INFORMATION:

Provider Name: _____ Practice: _____

Date of Referral: _____ Phone: _____ Fax: _____

PATIENT INFORMATION:

Please send pertinent clinical data, labs, tests, office notes, past treatments, medication/allergy lists, the current plan of care, & a copy of the patient's insurance card.

Patient Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Insurance Name: _____ Policy #: _____

Primary Language: _____ Interpreter needed? □ Yes □ No

Special Needs: _____

REFERRAL TYPE:

□ New Patient Consult
□ Established Patient Consult
□ Diagnostic Colonoscopy (medical problem)
□ Screening/Surveillance Colonoscopy (no symptoms)
□ EGD
□ EUS Consult
□ Hemorrhoid Banding Consult
□ FibroScan Consult
□ IBD Clinic Consult
□ Liver Clinic Consult
□ Interstim Consult
□ Orbera Gastric Balloon Consult
□ Other: _____

DIAGNOSIS/SYMPTOM(S): _____

PREFERRED LOCATION:

□ Winston-Salem □ Kernersville □ Clemmons

PREFERRED PROVIDER:

□ **1st available** (or urgent)
□ **No preference**
□ William Austin, MD
□ David Barry, MD
□ Brent Cengia, MD
□ Christopher Connolley, MD
□ Scott Cornella, MD
□ Robert Holmes, MD
□ Jason Jones, MD
□ Ryan McKimmie, MD
□ Henry Mixon, MD
□ Daniel Murphy, MD
□ Laura Patwa, MD
□ Randy Peters, MD
□ Blake Scott, MD
□ Brian Smith, MD
□ John Sweeney, MD

SCHEDULED APPOINTMENT INFORMATION (GAP TO RETURN TO REFERRING PROVIDER):

We will contact the patient for scheduling, & your office will then be notified by phone or fax with the status of the appointment.
Our goal is to communicate test results, treatment plans, or secondary referrals to the patient & PCP/Referring Provider within 3 business days of receipt.

Appt date: _____ Time: _____ Referring provider notified by fax / phone on: _____

□ Patient aware □ Unable to schedule appt □ Did not keep appt □ Patient r/s appt to: _____

Notes: _____