

REFERRAL FORM

Patient

Today's Date _____ Date of Birth _____

Patient Name _____

Last 4 Digits of SSN _____ Male Female

Phone: Home _____ Cell _____

Insurance Provider _____

Preferences

THIS REFERRAL IS URGENT!

First Available Appointment

First Available Doctor

Patient Prefers Male Provider

Patient Prefers Female Provider

Patient prefers one of the following providers below:

Azaan Akbar, DO

Syed Ali, MD

K. Mohan Bhoopal, MD

Rupa Fritz, MD

Michael Gorsky, MD

Ilyas Ikramuddin, DO

Rizwan Kibria, MD (Hospital)

Michael Loughlin, DO

Diklar Makola, MD, PhD

Rajeev Mehta, MD

Sanjay Sandhir, MD

Jonathan Saxe, MD

Lisa Stone, MD

Ben Thomas, DO

Drew Triplett, DO

Niaz Usman, MD

Benjamin Wheeler, MD

Appointment Request

Procedure

Colonoscopy Screening

Colonoscopy with Consult

Colonoscopy Only

Diagnosis: _____

EGD with Consult

EGD Only

Diagnosis: _____

EUS with Consult

EUS Only (send records)

Upper Lower

Diagnosis: _____

Bravo pH with Consult

Bravo pH Only

Diagnosis: _____

Consult for Evaluation/Treatment

Hemorrhoid Banding

Other

Reason: _____

InterStim

FibroScan

FibroScan with Consult

FibroScan Only

Diagnosis: _____

ICD 10: _____

Patient's pertinent medical records are included with this referral.

Locations

Clinic & Endoscopy Center:

Beavercreek (Indian Ripple Rd)

Beavercreek (Sylvania Dr)

Englewood (Miami Valley Hospital North)

Clinic Office Only:

Miamisburg (Byers Rd)

Referring Physician

Practice Name _____

Physician _____

Contact (in case of questions) _____

Address _____

Phone _____ Fax _____