GASTROENTEROLOGY PRACTICE ASSOCIATES

OLUFEMI ABIODUN, MD AND AYODELE OSOWO, MD

515 W. Mayfield Road, Suite # 250
Arlington, TX 76014
Phone: 817-468-7200
Fax: 817-468-7201

GI REFERRAL FORM

☐ **SEE ATTACHED DEMOGRAPHIC SHEET**

Patient Name:		DOB:
Address:		
Phone Number:	Patient's SS:	
Primary Insurance:		ID:
Subscriber:	Relationship to Patient:	
Secondary Insurance:		ID:
Subscriber:	Relationship to Patient: «Reltopatient1»	

REASON FOR CONSULTATION/ REFERRAL/ PROCEDURE:

RELEVANT HISTORY AND PHYSICAL EXAMINATION:

PLEASE FAX OR HAVE THE PATIENT BRING IN THE FOLLOWING INFORMATION:	
Copy of Office Notes	**Imaging Reports**
****Copy of Prior Colonoscopy / EGD Operative Reports with Pathology**	**Pertinent Labs (Especially if sending patient for Anemia / Elevated LFT's)**

☐ STAT ☐ ROUTINE

Referring Physician/ Facility: ____

Please fax form to: 817-468-7201

WE TRULY APPRECIATE ALL THE REFERRALS