Gastroenterology Practice Associates
GPA

Referral Form

Patient Name: _____

DOB: _____

Address: _____

Phone Number: _____

Email: _____

Dx Code/Reason for Referral: _____

Insurance Carrier: _____

Subscriber Number: _____

If HMO, please provide referral authorization information:

_____

Ordering Provider Name: _____

Ordering Provider Signature: _____

Please fax the patient's **last 2 office notes, recent labs and any pertinent imaging results**. If the patient has had a previous Colonoscopy and/or EGD, please fax the **procedure reports and pathology results**.

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Arlington, TX 76018
2625 E. Southlake Blvd. Ste 160
Southlake, TX 76092

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