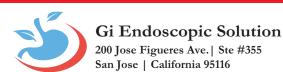
GASTROENTEROLOGY REFERRAL FORM



HOAN V. TRAN, M.D.

Board Certified Gastroenterology & Internal Medicine

Tel.: (408) 898-1168 Fax: (408) 898-1169 www.comingsoon

For your convenience, please complete this form and fax back to us at 408-898-1169, along with the relevant information. this is to help us better serve you and your patient. We will contact the patient and fax this sheet back to you with the date/ time within 24 business hours. For questions/ concerns, contact us

408-898-1168. Thank you for your referral.

REFERRING PHYSICIAN INFORMATION: Referring Physician:							
CONTACT PERSON:						Tel:	
						Fax:	
PATIENT GENERAL INFORMATION: Patient Name:							
ADDRESS:							
DOB:	SSN:			GENDER: MALE FEMALE		PCP (if known):	
HOME PHONE:	CELL PHONE:			WORK PHONE:		TODAY'S DATE:	
INSURANCE INFORMATION: Please fax copy of Insurance card (front and back sides)							
PRIMARY INSURANCE	ID#:				GROUP #:		
SECONDARY INSURANCE:	CONDARY INSURANCE: ID #:			GROUP #:			
* If patient's insurance requires a referral, please attach . This referral will need to have an authorization number from the insurance company *							
MEDICAL INFORMATION:							
PRIORITY LEVEL: ☐ URGENT ☐ NON URGENT			DIAGNOSIS:				
HEMOCCULT TEST DONE: ☐ YES					HEMOCCULT RESULTS: (check if applicable) ☐ POSITIVE ☐ NEGATIVE		
CHECK ALL THAT APPLY	CK ALL THAT APPLY						
	= Tiseles = Galistones, CDD						
	1						
☐ Acute hepatitis ☐	Dysphagia		☐ GI b	leeding/ hematochezia	☐ Otl	ner:	
* Please be sure to fax any medical records pertaining to the reason for visit, such as:							
Last office note, recent lab results, GI X-Rays, Endoscopy Reports, GI Pathology Reports, and patient's insurance card *							
THIS BOX BELOW IS FOR GI ENDOSCOPIC SOLUTION USE ONLY. WE WILL FAX OVER APOINTMENT DATE AND TIME							
APPOINTMENT DATE		APPOINTMENT TIME			PROVIDER		
Thank you for your referral. We will contact the patient to give them the appointment information.							