GASTROENTEROLOGY REFERRAL FORM

Gi Endoscopic Solution
200 Jose Figueres Ave.| Ste #355
San Jose | California 95116
Tel.: (408) 898-1168
Fax: (408) 898-1169
www.comingsoon

HOAN V. TRAN, M.D.
Board Certified Gastroenterology & Internal Medicine

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:	ID #:	GROUP #:

* If patient's insurance requires a referral, **please attach.**
This referral will need to have an authorizatiion number from the insurance company *

MEDICAL INFORMATION:	
PRIORITY LEVEL: ❑ URGENT ❑ NON URGENT	DIAGNOSIS:
HEMOCCULT TEST DONE: ❑ YES ❑ NO	HEMOCCULT RESULTS: (check if applicable) ❑ POSITIVE ❑ NEGATIVE

CHECK ALL THAT APPLY

❑ Abnormal Imaging	❑ Ascites	❑ Gallstones, CBD stones	❑ Melena
❑ Abnormal liver tests	❑ Biliarty obstruction	❑ Hemoccult positivity	❑ Persistent anusea & vomitting
❑ Acute hepatitis	❑ Chronix viral hepatitis	❑ Iron deficiency anemia	❑ Screening for colon cancer/ polyps
	❑ Dysphagia	❑ GI bleeding/ hematochezia	❑ Other:

* 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

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APPOINTMENT DATE	**APPOINTMENT TIME**	**PROVIDER**

Thank you for your referral. We will contact the patient to give them the appointment information.