***Gastroenterology Institute***
**Joseph M. Hathaway, Jr., MD**
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# FAX REFERRAL FORM

## ***Referring Physician Information***

**Referring MD: _____ PH #: _____ FAX#_____**

**Contact Person: _____ Date Sent: _____**

## ***Patient Information***

**PATIENT Name: _____**

**DOB: _____/_____/_____ SSN: _____-_____-_____ SEX: Male Female**

**Address: _____**

**City: _____ State: _____ Home #: ( ) _____-_____**

**Work #: ( ) _____-_____Cell#: ( ) _____-_____Emergency #: ( ) _____-_____**

## ***Insurance Information***

**Insurance Company: _____ _____**

**Policy #:_____Group #: _____**

**Subscriber's DOB: _____/_____/_____ Subscriber's SSN: _____-_____-_____**

**Patient/Subscriber's Employer: _____**

## ***Reason for Appointment***

**Office Consult** **Colonoscopy** **EGD** **Manometry/pH Probe Bravo**

Barrx Halo ERCP Capsule

Please include last two (2) office notes, recent labs and radiology tests. ***If you are referring a patient for a **screening colonoscopy**, please be aware that **not all** insurance companies **cover** this procedure and **patient should made aware of this and should be 50 years of age or older**.***

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**We have contacted your patient regarding their scheduled appointment**

Appointment Date: _____/_____/_____ Time: ____: ____AM/PM Arrive at: ____:____ AM/PM

Scheduled by: _____ _____

**A $25.00 fee will be charged to the patient's who fail to cancel their appointment without giving 24 hours notice.**