

MD Preference **First Available** Appointment / No MD Preference

- | | |
|---|--|
| <input type="checkbox"/> George C. Aragon | <input type="checkbox"/> Mark E. Murphy, MD |
| <input type="checkbox"/> Steven L. Carpenter, MD | <input type="checkbox"/> Mark R. Nyce, M.D. |
| <input type="checkbox"/> Charles W. Duckworth, MD | <input type="checkbox"/> Edward Rydzak, MD |
| <input type="checkbox"/> Allan Hardy, MD | <input type="checkbox"/> Ryan C. Wanamaker, MD |

Patients can reschedule appointments via: www.SavannahGI.com

Referring Practice Information		*** Appointment***	
Today's Date	Phone	Appt Date:	
Group Practice Name		Appt Time:	
Referring Physician		Physician:	
UPIN #		NPI #	
Refer/Appt Fax #	Medical Records Fax #	Location:	
		Contacted Patient:	Phone / Letter / Unable to Reach
		MRN:	
		Screen/Prob	
		New/Est	

Patient's Information *Name completed and remaining demographic information attached.*

First Name		Mid	Last Name	
Mailing Address				
City	State: GA or SC	Zip	Phone	
Date of Birth	Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Insurance Information *Insurance card attached, and referral number completed below.*

Primary Insurance		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other		
Referral #		Policy #		
Subscriber Social Security #		Subscriber's Date of Birth		
Policy belongs to (circle one) Patient Spouse Other				
Secondary Insurance		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other		
Policy #		Subscriber's Date of Birth		
Policy belongs to (circle one) Patient Spouse Other				

Patient History

Is the referral: **Routine** (1st available appt) **Routine Colon Screening** **Urgent Consult**

The above primary provider has attached a written report and would like to request a consult for the patient named above to evaluate the following condition:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Intestinal Gas Problems |
| <input type="checkbox"/> Alcoholic Liver Disease | <input type="checkbox"/> Gastro Esophageal Reflux Disease (GERD) | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rectal Complaints |
| <input type="checkbox"/> Food Intolerance | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Ulcers |

Other: