

**GASTROENTEROLOGY CONSULT REQUEST FORM**

**PLEASE FAX TO:  
627-3709 for Norfolk  
436-2262 for Chesapeake**

**IF THIS IS URGENT, PLEASE CALL DIRECT TO MICHELLE BETHEA, OFFICE  
MANAGER AT 436-3285 OR SUSAN DOVER, PRACTICE MANAGER  
AT 627-6416**

**DATE:** \_\_\_\_\_

**REFERRING DR:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**REFERRED TO:**

- |  |  |
|--|--|
| <input type="checkbox"/> FIRST AVAILABLE APPOINTMENT | <input type="checkbox"/> _____               |
| <input type="checkbox"/> MICHAEL SPERLING MD         | <input type="checkbox"/> DOUGLAS HOWERTON MD |
| <input type="checkbox"/> ALEX WILLIAMS MD            | <input type="checkbox"/> GARY PAYMAN MD      |
| <input type="checkbox"/> SCOTT YAGEL MD              | <input type="checkbox"/> BRUCE WALDHOLTZ MD  |

**REASON FOR REFERRAL (DIAGNOSIS):** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY/STATE/ZIP:** \_\_\_\_\_

**SEX(M/F):** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**PHONE NUMBERS:** \_\_\_\_\_ **HOME**  
\_\_\_\_\_ **WORK**  
\_\_\_\_\_ **CELL**

**INSURANCE INFO:**  
**PRIMARY:** \_\_\_\_\_ **ID#** \_\_\_\_\_

**SECONDARY:** \_\_\_\_\_ **ID#** \_\_\_\_\_

**+++++++APPOINTMENT CONFIRMATION+++++++**

**DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **PROVIDER:** \_\_\_\_\_

**\*\*PLEASE FAX MOST RECENT H&P, LABS, LAST COLONOSCOPY AND/OR\*\*  
\*\*ENDOSCOPY NOTE, MEDICATION LIST AND REFERRAL.\*\*  
THANK YOU FOR THIS REFERRAL!**