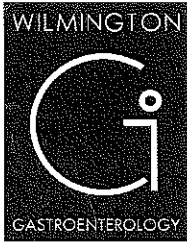


FAX REFERRAL FORM



**WILMINGTON
GASTROENTEROLOGY
ASSOCIATES, PA**

DR. CLINTON MEYER
DR. JOSEPH KITTINGER
DR. WILLIAM KING
DR. ROBERT D.J. HENIHAN
DR. STEVEN KLEIN
DR. D.SPENCER CARNEY
DR. MARY SAUER

JEAN NICHOLS, PAC
HEATHER GOLDSTEIN, PAC
WENDY HUDSON, PAC
KRISTIN MAGGI, PAC
JENNIFER PRESTON, PAC
KATY ROBINETTE, PAC
STACEY PENNINGTON, PAC
SARAH MAZUROWSKI, PAC

5115 OLEANDER DRIVE
WILMINGTON, NC 28403
PHONE: (910) 362-1011
FAX: (910) 202-3844 X

WGA chart # _____

Please complete this form and fax with the PATIENT'S LAST OFFICE VISITS, ALL RECENT LAB AND X-RAY RESULTS, ANY PREVIOUS COLON/EGD REPORTS and PATHOLOGY, COPIES OF INSURANCE CARDS.

*****IF YOU ARE REFERRING THIS PATIENT FOR A SCREENING COLONOSCOPY, PLEASE BE AWARE THAT ALL INSURANCE PLANS DO NOT COVER THIS AND PT NEEDS TO BE AT LEAST 50 YEARS OF AGE *****

PATIENT NEEDS TO BRING INSURANCE CARDS AND LIST OF MEDICATIONS TO THEIR APPOINTMENT

Referring MD _____ PH # _____ FAX# _____

MD's Mailing Address: _____ NPI# _____

Sender's Name _____ Date Sent to WGA: _____

Patient's Primary Care Physician: _____ PH#: _____

PATIENT'S Name _____ Male Female (circle)

DOB ____ / ____ / ____ SSN ____ - ____ - ____ HM PH# _____

ADDRESS _____ WK PH# _____

_____ CELL PH# _____

INSURANCE COMPANY: _____ ID#: _____

GROUP #: _____ INSURED EMPLOYER: _____

++++PLEASE BE AWARE THAT WE ARE OUT OF NETWORK WITH AETNA++++

****PLEASE CHOOSE TYPE OF APPOINTMENT NEEDED****

-Endoscopic Ultrasound (EUS) and DX: _____

-COLONOSCOPY and DX: _____

-EGD and DX: _____

-OFFICE CONSULT and DX: _____

Physician Requested _____ Can your patient see 1st available Physician Assistant (circle) Y N

We have contacted your patient and scheduled this appointment:

Appointment Date: ____ / ____ / ____ Time: ____ AM / PM ARRIVE AT _____

Prep Date for procedure: ____ / ____ / ____ Time: ____ AM / PM ARRIVE AT _____

Appointment made with: _____ PA-C / MD

Scheduler's Name _____ Questions, call: (910) 362-1011 Ext: _____

Please ask your patient to call us if this appointment needs to be rescheduled. A \$25.00 fee will be charged if appointment is not cancelled within 24-hours **Fax medical records to (910) 202-3844*