GI PATIENT REFERRAL FORM

Date: _____ Would you like us to contact the patient? ☐Yes ☐ No

REFERRING MD: _____

REFERRED TO:

☐ James Torosis, MD ☐ Vicky Yang, MD ☐ First Available

☐ Daniel Rengstorff, MD ☐ Cynthia Leung, MD

Patient's Name: _____

Patient's Insurance Type: ☐ HMO ☐ PPO ☐ POS ☐ Medicare

Patient's Insurance Provider: ☐ AETNA ☐ BLUE CROSS ☐ BLUE SHIELD

☐ CIGNA ☐ HEALTHNET

OTHER: _____

Patient Phone Number: _____

Dx/Reason: _____

PRIORITY: ☐ Urgent (<72 hours) ☐ Routine (<2 weeks)

SPECIAL CONCERNS:

☐Sleep apnea ☐CHF ☐Diabetes ☐Renal insufficiency ☐Hx coronary valvular disease

☐Difficult sedation/High tolerance ☐On ASA/Coumadin/Plavix/Lovenox (please circle)

SERVICE REQUESTED:

Consultation with ☐EGD ☐Colonoscopy ☐ERCP ☐Capsule Endoscopy

☐BARRX ablation of Barrett's esophagus ☐Bravo ☐24hr pH ☐PEG tube

Please Fax to 650-368-3836 and we will arrange for authorization and respond with 24hrs with confirmation. If urgent, please call.