LANDMARK DIGESTIVE HEALTH

Physician Referral Form

Is this referral urgent? Yes ◌ No ◌

Is this referral for? Specialist/Consultation ◌ Procedure/Testing only ◌

Please fill out this form completely, include demographics, insurance card, any clinical documentation relevant to this referral, progress note(s), procedure(s), pathology, imaging, and/or labs, and fax all documents to 270-922-2505.

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____

Primary Phone: _____ Date of Birth: _____ Gender: ____ Last 4 SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Insurance: _____ Insurance ID: _____ Policy Holder: _____

Preferred Language: _____ Need Interpreter: Y/N

Referral Information:

Reason for Referral:

_____

Diagnosis: _____ ICD 10: _____

Referring Provider:

Provider First Name: _____ Provider Last Name: _____ Title: ____

Phone: _____ Fax: _____ NPI: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Form Completed By: _____

Physician Signature: _____