LANDMARK
DIGESTIVE HEALTH

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Referral Form

Is this referral urgent: ☐ YES ☐ NO

Purpose of Referral: ☐ Specialist/Consultation ☐ Procedure/Testing only

Please fill out this form completely. Please include demographics, insurance card, any clinical documentation relevant to this referral, progress note(s), procedure(s), pathology, imaging, and/or labs. Please fax all relevant 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: ☐ YES ☐ NO

REFERRAL INFORMATION

Reason for Referral: _____

Diagnosis: _____ ICD 10: _____

Referring Provider Name: _____ Title: _____

Phone: _____ Fax: _____ NPI: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Form Completed By: _____

Physician Signature: _____ Date: _____