Springfield Gastroenterology
2355 Derr Road, Suite A
Springfield, Ohio 45503
springfieldgastro.com

| Scheduling | |
|---|---|
| Fax Number | (937) 629-3285 |
| Phone Number | (937) 629-0100 |

# Easy G.I. Referral

Reset Form

Please save and email your completed form to gastro@springfieldgastro.com.

## Patient Information

Today's Date _____

Last Name *(please print)* _____ First Name _____

Date of Birth _____ Daytime Phone Number _____

Home Phone Number _____ Cell Phone Number _____

Insurance Provider _____ Last 4 Digits of Patient's SSN _____

## Patient Preferences

My patient would prefer to be seen by:

☐ **First available provider**

The following physician:

☐ **Challa Ajit M.D.**

## Referral Information

☐ **Consult Urgent** ☐ **Consult Routine**

| | | | | |
|---|---|---|---|---|
| ☐ Change in bowel habit | ☐ Constipation | ☐ Diarrhea | ☐ GI Bleed | ☐ Rectal bleed |
| ☐ Anemia | ☐ Hepatitis C | ☐ Hepatitis B | ☐ NASH/NAFLD | ☐ Abnormal LFT.s |
| ☐ Liver lesion/mass | ☐ Abdominal pain | ☐ GERD/Heart burn | ☐ Non Cardiac Chest Pain | |
| ☐ Crohn's | ☐ Weight Loss | ☐ Colitis | ☐ Other _____ | |

### Procedures

| | | | |
|---|---|---|---|
| ☐ Bravo pH / Gerd Study *(48 hour acid study)* | ☐ Screening Colonoscopy | ☐ Hemorrholdal Banding | ☐ Fibroscan |
| ☐ Diagnostic EGD | ☐ Video Capsule Endoscopy | ☐ Diagnostic Colonoscopy | ☐ Smart Pill |

***Please include patient's pertinent medical records, insurance card, and demographics with this referral.***

## Referring Physician

Physician Name

Physician Phone Number Physician Fax Number

Contact Name (in case we have any questions)

*Thank you for trusting us with the care of your patient.*
*We will notify your office when this appointment is scheduled.*

## Office Use Only

Appointment Date Time Dr.

Attempt 1 Attempt 2