

Winston-Salem
 Phone (336) 713-7777
 Fax (336) 713-7322

Greensboro
 Phone (336) 713-7777
 Fax (336) 716-6361

High Point
 Phone (336) 802-2105
 Fax (336) 802-2106

Wilkes
 Phone (336) 903-6820
 Fax (336) 903-6821

Please **complete the entire form and attach relevant medical records** such as clinic notes, endoscopy reports, path reports, labs, and imaging results.

Patient Information

Last Name:	First Name:	Middle Name:
Date of Birth:	Phone:	Gender Assigned at Birth:
Street Address:		
City:	State:	Zip:
Insurance: Yes or No (If yes, attach copy of both sides of Insurance card)		

Referring Provider Information

Referring Provider Name:	
Practice Name:	
Street Address:	City, State, Zip:
Phone:	Fax:

Select Diagnosis for Referral

<input type="radio"/> Biliary Disease <input type="radio"/> Pancreatitis <input type="radio"/> Pancreatic Disease <input type="radio"/> GI Malignancy	<input type="radio"/> GERD <input type="radio"/> Barrett's Esophagitis <input type="radio"/> Peptic Ulcer Disease <input type="radio"/> Diarrhea <input type="radio"/> Constipation	<input type="radio"/> Abdominal Pain <input type="radio"/> Anemia <input type="radio"/> GI Bleeding <input type="radio"/> Celiac Disease <input type="radio"/> Internal Hemorrhoids <input type="radio"/> IBS/Functional	<input type="radio"/> IBD <input type="radio"/> Crohn's <input type="radio"/> Ulcerative Colitis	<input type="radio"/> Esophageal Dysphagia <input type="radio"/> Achalasia <input type="radio"/> Gastroparesis <input type="radio"/> Intestinal Motility Disorder <input type="radio"/> Fecal Incontinence	<input type="radio"/> Abnormal LFTs <input type="radio"/> Acute Hepatitis <input type="radio"/> Chronic Viral Hepatitis <input type="radio"/> Cirrhosis <input type="radio"/> Liver Lesion/Cancer <input type="radio"/> Other <hr/>
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Clinical question(s) to be addressed: _____