VALDOSTA
Gastroenterology Associates
and
Endoscopy Center

Eric M. Ward, MD **C. Allen Woods, Jr., MD** **Kathryn C. Watt, NP**

Physician Fax Referral Form

Fax to 229-247-1084
Please include:

- **This form**
- **Any relevant medical records if appointment is diagnostic**
- **Patient demographics and front/back of insurance card**
- **Physician referral if required by the insurance company**

Date: _____ **Referring Office Contact Person:** _____

Referring Physician: _____

Telephone # _____ Fax # _____

Patient Information – Complete only patient name if attaching demo sheet and ins. card

Name: _____ Date of Birth: _____

Address: _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Appointment Information:

Procedure Needed: ☐ EGD ☐ Colonoscopy ☐Other _____

☐ Patient needs GI office visit prior to procedure ☐ Direct referral for procedure

Reason for referral: ☐ Colon Screening ☐Diagnostic (list GI problems) _____

Desired Time Frame of Patient Appointment: ☐ Routine ☐ ASAP ☐ First Available

Physician requested or specified: _____

We will schedule your patient an appointment or attempt to contact the patient and return this sheet back to you within 48 business hours. Thank You For Your Referral!

Follow-UP Information to be Completed by VGA/VEC

Scheduled: ☐EGD ☐Colon ☐Other _____ Date/Time _____ Physician_____
☐Left Msg. for PT to contact office for appt: _____ Date/Time _____Date/Time _____Date/Time ____
Initials

☐Referral letter mailed to patient to contact office. _____ Date _____ Initials