GI Referral Form

Referring Provider: ____________________ Office Contact: ________________ Date: _____ / _____ / ______

Referring Office Phone: ______________________________ Referring Office Fax: _________________________

Patient Information

Patient Name: ____ DOB: _____ / _____ / ______

Home Phone #: _________________________________ Cell Phone #: ___________________________________

Referral for: ☐ Office Consult ☐ Colonoscopy ☐ Upper Endoscopy (EGD)

Reason for Referral: ____
(Diagnosis or Symptoms)

Referred to:

☐ **Benjamin Shepherd, DO**
☐ **Deone Walls, CRNP**
2525 US HWY 431, Suite 220
Boaz, AL 35957
Tel: (256) 840-4840
Fax: (256) 840-4844

☐ **Chad Sisk, DO**
7938 AL HWY 69, Suite 310
Guntersville, AL 35976
Tel: (256) 571-8600
Fax: (256) 571-8640

☐ **Winter Wilson, DO**
☐ **Jessica Howard, CRNP**
55 Rowe Drive, Suite C
Guntersville, AL 35976
Tel: (256) 571-8810
Fax: (256) 571-8880

Please Attach:
☐ Patient Demographic Record, including insurance info
☐ Most current office note
☐ Most recent Lab results
☐ Recent diagnostic imaging (CT or US)

If your patient's needs are emergent, please call the office directly.

MSNA OFFICE USE ONLY

☐ **Patient Scheduled**
Shepard / Sisk / Wilson
Walls / Howard
Date / Time of Scheduled Visit: _________________ / ____________________
Thank you for your referral! We appreciate the opportunity to participate in your patient's care!

☐ **Patient NOT Scheduled**
Shepard / Sisk / Wilson
Walls / Howard
Reason: ____
Thank you for your referral! However, we have been unsuccessful in scheduling this patient. Please contact the patient for appropriate follow-up. Feel free to call our office with any questions.

Attempt Contact Log: 1. _____________________ 2. _____________________ 3. _____________________
Date / Time *Date / Time* *Date / Time*

Completed By: ____________________________ **Date Faxed to Referring Physician:** _____ / _____ / ______

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