



PATIENT REFERRAL FORM

Referring or Primary Care Physician: _____ Phone #: _____

Referring to: Dr. C. Randall ** Dr. R. Havranek ** Dr. D. Stump ** Dr. V. Zurita **Dr. C. Fincke

Location: Clinic on Datapoint Clinic @ NIX on Broadway Fredericksburg Clinic

Patient Name: _____

Telephone #: (home) _____ (work) _____

DOB: _____ SS#: _____ Insurance : _____

Insurance I.D.#: _____

Exam requested to be performed:

___ Office Consult ___ Colonoscopy Screening (Asymptomatic) ___ Colonoscopy Problem

___ Lactose breath test ___ EUS ___ ERCP ___ ENDO

___ Fructose breath test ___ Bacterial Overgrowth ___ Esophageal Mano

___ H-pylori breath test ___ Pill Cam (Sm. Bowel or ESO) ___ 24 hr Ph Probe

* ___ Remicade Trtmt.--**Necessary requirements: Pt. Weight _____; fax all records

**Treatment will not be scheduled w/o necessary medical records.

Diagnosis (Reason for referral): _____

Current Medications: _____ Allergies: _____

SBE Prophylaxis needed: _____ YES _____ NO

Please fax completed forms to: 210-615-8313, Thank You