Digestive Health Specialists, P.A.

FOR CONSULTATION OR PROCEDURE REFERRAL FAX TO DHS AT 662-680-5654

PATIENT INFORMATION:

Patient Name:_____

Address_____

_____

Social Security#_____ DOB_____

Phone #: Home_____ Cell_____ Work_____

INSURANCE: Please fax a copy of the front and back of insurance card.

Primary Carrier: _____ Policy Holder: Self Spouse Child

Policy #_____ Group#_____

Secondary Carrier: _____ Policy Holder: Self Spouse Child

Policy #_____ Group#_____

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name:_____

Office Phone:_____ Fax#_____

Location Preference: Tupelo_____ Starkville _____

Consult for: COLON (diagnostic or screening) EGD Office Visit Other:_____

Note – Medicare and Blue Cross Healthy You covers screening colonoscopy. These patients do not require an office visit unless specified by the referring physician. Please indicate if this patient has screening benefits.

Diagnosis for referral _____

Special request:_____

FOR DIGESTIVE HEALTH USE ONLY
APPT SCHEDULED FOR:_____ with Dr._____
Date Patient Contacted:_____ Date Form Faxed to referring MD_____
Signature:_____