Charlotte Gastroenterology & Hepatology

EASY ACCESS GI REFERRAL FORM

Thank you for choosing Charlotte Gastroenterology and Hepatology as your GI referral of choice. In keeping with our commitment of excellence in customer service, we developed this "Easy Access GI" form to provide easier access to our appointment schedule. Simply complete the information below and fax this form back to the number provided. We have a fax line dedicated only to receiving these appointment referrals:

EASY ACCESS GI
FAX LINE: (704) 602-6576

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PATIENT NAME: _____ **DATE:** _____

ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

INSURANCE CARRIER NAME: _____

HOME PHONE: _____ **MOBILE:** _____ **WORK:** _____

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Call patient to confirm appointment? Yes ❑/No ❑ **Appointment date by Fax ❑ or Phone ❑?**

Appointment date:_____/Time:_____

Reason for referral: _____ ❑ **Routine /** ❑ **Stat Request**

Physician requested: _____ Locations requested: _____

Referring Physician/Practice: _____ Phone No.: _____

Referral Coordinator: _____ Fax No. _____

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Charlotte Gastroenterology & Hepatology

EASY ACCESS GI REFERRAL FORM

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ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

INSURANCE CARRIER NAME: _____

HOME PHONE: _____ **MOBILE:** _____ **WORK:** _____

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Appointment date:_____/Time:_____

Reason for referral: _____ ❑ **Routine /** ❑ **Stat Request**

Physician requested: _____ Locations requested: _____

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Charlotte Gastroenterology & Hepatology

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ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

INSURANCE CARRIER NAME: _____

HOME PHONE: _____ **MOBILE:** _____ **WORK:** _____

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Appointment date:_____/Time:_____

Reason for referral: _____ ❑ **Routine /** ❑ **Stat Request**

Physician requested: _____ Locations requested: _____

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Charlotte Gastroenterology & Hepatology

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ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

INSURANCE CARRIER NAME: _____

HOME PHONE: _____ **MOBILE:** _____ **WORK:** _____

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Appointment date:_____/Time:_____

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Physician requested: _____ Locations requested: _____

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Charlotte Gastroenterology & Hepatology

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ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

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Physician requested: _____ Locations requested: _____

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Charlotte Gastroenterology & Hepatology

EASY ACCESS GI REFERRAL FORM

Thank you for choosing Charlotte Gastroenterology and Hepatology as your GI referral of choice. In keeping with our commitment of excellence in customer service, we developed this "Easy Access GI" form to provide easier access to our appointment schedule. Simply complete the information below and fax this form back to the number provided. We have a fax line dedicated only to receiving these appointment referrals:

EASY ACCESS GI
FAX LINE: (704) 602-6576

You have a choice, by fax or phone, in how you receive the information regarding the appointment. We will also call the patient direct, if you so choose. If referring to a particular physician within our practice, be sure to include his/her name and location choice. ***Please have your Medical Records Dept. fax records as soon as possible prior to the scheduled appointment to 704-375-6970.*** Our appointment coordinators are available to assist you with any of your appointment needs. Again, thank you for choosing Charlotte Gastroenterology and Hepatology!

PATIENT NAME: _____ **DATE:** _____

ADDRESS: _____ **CITY/ST/ZIP:** _____

DOB: _____ **SOCIAL SECURITY NO.** _____

INSURANCE CARRIER NAME: _____

HOME PHONE: _____ **MOBILE:** _____ **WORK:** _____

****

Call patient to confirm appointment? Yes ❑/No ❑ **Appointment date by Fax ❑ or Phone ❑?**

Appointment date:_____/Time:_____

Reason for referral: _____ ❑ **Routine /** ❑ **Stat Request**

Physician requested: _____ Locations requested: _____

Referring Physician/Practice: _____ Phone No.: _____

Referral Coordinator: _____ Fax No. _____

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