Texarkana Gastroenterology Consultants

Phone (903) 792-8030 Fax (903) 793-0844

Date: _____ **Outpatient Referral Form**

Referred to: ◯ **First Available** ◯ John Cozart,MD ◯ Laura Balmain,MD ◯ Jay Boehmke,DO ◯ Brian So, MD

Referred From: _____

Office Contact: _____ Phone: _____

Patient Information

Name: _____ DOB: _____

Address: _____ Age: _____ ◯ M ◯ F

City: _____ State: ____ Zip: _____ SSN: _____

Phone: _____ Cell: _____ Preferred: ◯ Cell ◯ Phone

Patient Email: _____

Insurance Information

Primary: _____ ID #: _____ Group: _____

Insured Name: _____ Insured DOB: _____

Secondary: _____ ID #: _____ Group: _____

Insured Name: _____ Insured DOB: _____

Basic Medical Information

Height: _____ Weight: _____ Recent hospitalization in last 3 months? ◯ Yes ◯ No

Known Allergies (check all that apply) : ◯ NO KNOWN ALLERGIES

◯ Penicillin ◯ Sulfa ◯ Latex ◯ Morphine

◯ Aspirin ◯ Codeine ◯ Iodine ◯ Demerol

◯ Other (Specify): _____

Hx of heart disease? ◯ Yes ◯ No Hx of endocarditis? ◯ Yes ◯ No

Heart valve replacement? ◯ Yes ◯ No

Hx of blood disorder? ◯ Yes ◯ No If yes, please explain: _____

_____

Is patient on blood thinners? ◯ Yes ◯ No Medication Type: _____

_____

Is patient a diabetic: ◯ Yes ◯ No Describe diabetic medication: _____

_____

Referring Diagnosis: _____

Services Requested: ◯ EGD ◯ Colonoscopy ◯ PEG Tube Placement ◯ Consultation

***** Please provide a listing of all medications and copy of last office note. *****