



# Christopher D. Sarzen MD PC

## PATIENT REFERRAL FORM

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ INSURED'S NAME: \_\_\_\_\_

*(Please attach a copy of the front and back of the patient's insurance card)*

Is the Patient On Blood Thinners?  No  YES TYPE: \_\_\_\_\_

Does the Patient Have a Pacemaker?  No  YES

PLEASE CIRCLE THE TYPE OF APPOINTMENT YOU ARE REQUESTING:

CONSULTATION

EGD

COLONOSCOPY

FLEXSIG

### PLEASE CIRCLE THE REASON FOR THE REFERRAL

#### COLONOSCOPY/FLEX SIG

#### EGD—EGD/DIL

Anal/Rectal Polyp/Mass	569.0	Personal HX	V12.72*
Diverticulitis	562.13	Adenomatous Polyps	
Diverticulosis	562.10	Family HX	V18.5*
Anorectal Bleed	569.3	Adenomatous Polyps	
Diarrhea	787.91	Personal HX Colon CA	V10.05*
Change in Bowel Habits	787.99	Family HX Colon CA	V16.0*
Guiac (+) Stool	792.1	Abdominal Pain	789.00*
Iron Deficiency/Anemia	280.9	Constipation	564.00*
Melena/Hematochezia	578.1		
Ulcerative Colitis/Crohns	555.9		
		<b>Screening — No Symptoms</b>	

Dysphagia/Odynophagia	787.2
Early Satiety	780.94
Epigastric Pain	789.06
GERD	530.81
Melena	578.1
Barrett's	530.85
Nausea/Vomiting	787.01
Abnormal Weight Loss	783.21
Hematemesis	578.0
Gastric Ulcer	531.00
Duodenal Ulcer	532.00
Peptic Ulcer	533.00
Abdominal Pain	789.00*
Dyspepsia	536.8
Chest Pain — Unspec.	786.50

OTHER DIAGNOSIS: \_\_\_\_\_

**PLEASE ATTACH A COPY OF ANY PERTINENT OFFICE DICTATION AND/OR TEST RESULTS (LAB/X-RAY)**

If the patient's insurance company requires a referral, we will need your office to request one. Our scheduling department will call your patient within 1 business day of receiving your referral to schedule the procedure and/or office visit (consult). Our staff will also recertify the procedure and forward the consult report or procedure report to your office as soon as it is completed. If we are unable to schedule your patient or the patient does not wish to schedule at this time — you will be sent a fax notification. If you have any questions, please don't hesitate to contact us at (404) 303-3003. Thank you for your referral.

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE # \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE FAX THIS FORM TO: (404) 303-0036