# NEW PATIENT REFERRAL FORM

***Please refer to the following referral criteria in order to assist in the patient's care in a timely manner.***

**Patient Name:_________________________________________DOB:____________**

**Email :______________________________Best Contact Number :________________**

**ICD 10 & Descriptions :___________________________________________________**

**The following documents are REQUIRED with your Referral :**

- ❑ Outgoing Referral, Insurance Authorization & Demographics
- ❑ H&P, Most Recent Clinical Notes
- ❑ **Colonoscopy/EGD:**
  - ❑ Last EGD/Colonoscopy Operative Report
  - ❑ Surgical Pathology Results

***Please notate if patient has never had a colonoscopy/EGD in the past or it has been over 10 years.***

- ❑ **Genetic Testing**
- ❑ **Breast Case :**
  - ❑ Last Mammogram Report
  - ❑ Ultrasound Report
  - ❑ Biopsy Report and Pathology Results if available
  - ❑ MRI Report if available

- ❑ **Hernia, GI , Gallbladder, Gtube , Hemorrhoids, ETC :**
  - ❑ Please send all pertaining reports
    - ❑ Radiology - Diagnostic Imaging
    - ❑ Pathology , Biopsy
    - ❑ Operative Reports

- ❑ **Melanoma Case:**
  - ❑ Please send all pertaining reports
    - ❑ Radiology - Diagnostic Imaging
    - ❑ Pathology , Biopsy
    - ❑ Operative Report
    - ❑ Photo and size of melanoma

❑ ***For any other referrals please send diagnostic imaging, pathology and operative report, lab test , etc .***

**Please inform the patient that our staff will be contacting them to schedule an appointment.**

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