# GI PATIENT REFERRAL FORM

**Date:** _____ Would you like us to contact the patient? ☐Yes ☐ No

**REFERRING MD:** _____

**REFERRED TO:**

☐ James Torosis, MD ☐ Vicky Yang, MD ☐ First Available

☐ Daniel Rengstorff, MD ☐ Cynthia Leung, MD

**Patient's Name:** _____

**Patient's Insurance Type:** ☐ HMO ☐ PPO ☐ POS ☐ Medicare

**Patient's Insurance Provider:** ☐ AETNA ☐ BLUE CROSS ☐ BLUE SHIELD

☐ CIGNA ☐ HEALTHNET

OTHER: _____

**Patient Phone Number**: _____

**Dx/Reason:** _____

**PRIORITY:** ☐ Urgent (<72 hours) ☐ Routine (<2 weeks)

**SPECIAL CONCERNS:**

☐Sleep apnea ☐CHF ☐Diabetes ☐Renal insufficiency ☐Hx coronary valvular disease

☐Difficult sedation/High tolerance ☐On ASA/Coumadin/Plavix/Lovenox (please circle)

**SERVICE REQUESTED:**

**Consultation with** ☐EGD ☐Colonoscopy ☐ERCP ☐Capsule Endoscopy

☐BARRX ablation of Barrett's esophagus ☐Bravo ☐24hr pH ☐PEG tube

**Please Fax to 650-368-3836 and we will arrange for authorization and respond with 24hrs with confirmation. If urgent, please call.**