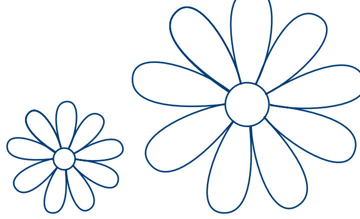


Referral Form
Gastroenterology

Julie Farrer, M.D.
James E. Martinez, M.D.

4705 Montgomery NE, Suite 102
Albuquerque, NM 87109
Pho: 505.727.7833
Fax: 505.727.6944

PLEASE FAX REFERRAL FORM, PATIENT DEMOGRAPHICS AND INSURANCE CARD(S) TO 505.727.6944

Patient name: ______________________________ DOB: ______________

Home phone: ______________________ Cell phone: ______________________

Insurance: ____

Referring provider office name: ______________ Referring provider office phone: ______________

Primary care provider name (if different than referring): ______________ PCP office phone: ______________

Reason for referral: ____

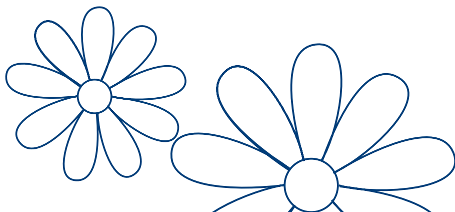
____

Relevant labs and/or radiologic findings: ______________________________

____

❑ Screening colonoscopy only

WE GLADLY ACCEPT MOST INSURANCE PLANS.



Lovelace
Medical Group