

# Referral Form Gastroenterology

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**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: \_\_\_\_\_

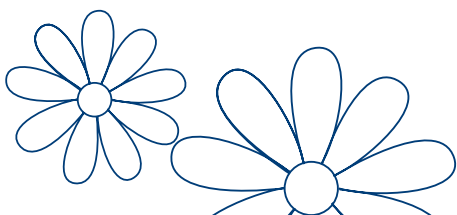
Primary care provider name (if different than referring): \_\_\_\_\_ PCP office phone: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Relevant labs and/or radiologic findings: \_\_\_\_\_

Screening colonoscopy only

**We accept most major insurance plans**, including Blue Cross and Blue Shield of New Mexico, Aetna Medicare & Commercial, TRICARE, Medicare, all Centennial/Medicaid plans, including Presbyterian Centennial Care, True Health New Mexico, Western Sky Community Care and United Retiree Health Care Authority and many others.



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