QUEEN CITY
GASTROENTEROLOGY
& HEPATOLOGY

320 Lillington Ave, Suite 101
Charlotte, NC 28204-3189
Tel (704) 362-4403
Fax (704) 362-4405

PATIENT REFERRAL FORM
FAX # 704-362-4405

Last Name | First Name | Middle Initial | DOB

Street | City | State | ZIP Code

Cell Phone ( ) | Home Phone ( ) | Business Phone ( )

Primary Insurance | Insurance ID / Group #

Referred By (MD/DO/PA-C/CNP) | NPI #

Phone # ( ) | Fax # ( )

Service(s) requested (check all that apply): ☐ Consultation ☐ Colonoscopy ☐ Direct Access ☐ Upper Endoscopy ☐ Capsule Endoscopy ☐ Hemorrhoid Ligation ☐ Other _____

Preferred day(s) of week _____ A.M. or P.M. (circle preference)

Indication/Symptoms _____

_____

Current Medications _____

_____

Significant History/CoMorbidities _____

_____

Medication(s) or Condition(s) (check all that apply): ☐ Coumadin ☐ Plavix ☐ Diabetes ☐ Pacemaker/AICD ☐ Artificial Valve ☐ Rheumatic Fever ☐ Latex Allergy

To be completed by Queen City Gastroenterology & Hepatology, PC

Date of Appointment _____@_____ Scheduled by _____

Appointment/Info/Prep given/mailed to patient _____

THANK YOU!