Stephen E. Buckley, M.D.
William M. Farmer, D.O.
H. Creed Fox, M.D.
C. Troy Morrissette, M.D.
Cynthia A. Townsend, CFNP

REFERRAL FORM

** AN APPOINTMENT WILL NOT BE MADE UNTIL WE RECEIVE RECORDS AND INSURANCE CARDS. PLEASE SEND COPY OF LAST OFFICE VISIT, LABS, RADIOLOGY AND ANY OTHER DIAGNOSTIC TEST WITH REFERRAL FORM. **

Referring Physician

Referring Physician ________________________ Date ___ / ___ / ___ Phone ______________

Referring Office Contact Person ________________________________ Fax ________________

Mailing Address ____

Patient Demographics (Must Be Complete)

First Name __________________________ MI _____ Last Name _________________________

Date of Birth ___ / ___ / ___ Gender (M) / (F) SS Number __________________________

Home Phone _______________ Work Phone _______________ Cell Phone ______________

Address ____

Referral

Diagnosis _________________________ Open Access Colonoscopy _____________________

Has the patient been seen by a GI Doctor in the past? (Y) / (N)

Physicians Name ____

Has the patient had any of the following diagnostic tests?

☐ COLONOSCOPY ☐ EGD ☐ LAB ☐ X-RAYS

Patients Insurance ____
(Please send copy of card)

**** Office Use Only ****

Appointment Date / Time _______________ Scheduled By ______________________________

Doctors are certified in Internal Medicine and Gastroenterology by the American Board of Internal Medicine