GI REFERRAL REQUEST

PATIENT'S NAME: ______________________________ PATIENT'S DOB: ____________________

BEST CONTACT NUMBER: ________________________ EMAIL: ____________________________

REFERRING PROVIDER: ______________________REFERRING PROVIDER FAX: __________________

Does the patient have a history of: ❒ Stroke. ❒ MI. ❒ Heart Surgery. ❒ Dialysis.
Does the patient take any blood thinners? ❒ Yes. ❒ No.
Type of insurance: ❒ PPO ❒ Medicare ❒ Cash ❒ HMO ____________________________

REASON FOR REFERRAL:

❒ EGD ❒ Colonoscopy ❒ Hemorrhoids ❒ Dietitian ❒ H pylori breath test

❒ Consultation: ____

REFERRING TO:

❒ Dr. Shahrooz Bemanian ❒ Dr. Paul Lee ❒ Dr. Matthew Oman

❒ Dr. Victor Yu ❒ Tatiana Keay, RD ❒ 1st Available MD

❒ Based on patient preference

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113 Waterworks Way, Ste. 155
Irvine, CA 92618

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Please fax or email this form to:

Digestive Disease Consultants of OC
949-612-9091
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Thank you for your trust in caring for your patient!