Gastroenterology of Greater Orlando

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Express Referral Form

Date: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Patient Name: _____ DOB: _____

Procedure: ☐ Colonoscopy ☐ EGD ☐ Colonoscopy and EGD

Referral Status: ☐ Routine ☐ Urgent

Diagnosis: _____

Past Medical History:

_____
_____
_____
_____

Allergies:

_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____

Note: Any Anticoagulants/ Anti-Inflammatories or Blood Thinners needs to be discontinued at the recommendation of the prescribing physician.

Vital Signs: BP _____ WT _____ Pulse _____ Respiration _____

Lungs: _____ Heart: _____ (If pacemaker in place please send a copy of the card)

_____ _____

Requesting Physician's Signature Date

The completed form needs to be faxed to 386-668-2228. Please ensure to attach patient demographics, insurance information, last office visit note, any pertinent labs, radiology and clearances.

2884 Wellness Ave
Orange City, FL 32763
(386) 668-2221

860 Peachwood Dr
DeLand, FL 32720
(386) 469-7993

1319 S International Pkwy, Ste 1171
Lake Mary, FL 32746
(407) 749-6656