DIGESTIVE DISEASE ASSOCIATES

APPOINTMENT SCHEDULING

352-331-8902 Fax: 352-331-5591

PATIENT INFORMATION

REFERRAL

REFERRING PHYSICIAN

DDA USE ONLY

FAX REFERRAL FORM

Date _____ DOB _____ Sex _____ Social Security Number _____

Last Name (please print) _____ First Name _____

Address _____ City/State/Zip _____

Home Phone Number _____ Cell Phone Number _____

Primary Insurance Plan and Policy Number _____

Secondary Insurance Plan and Policy Number _____

PATIENT PREFERENCES

My patient would prefer to be seen by:

- ❑ Thomas R. Beers, MD
- ❑ Gabu Bhardwaj, MD
- ❑ Payam Chini, MD
- ❑ Dennis P. Collins, MD
- ❑ Ryan D. Heath, MD
- ❑ Jason D. Hallman, MD
- ❑ Ronald C. Lee, MD
- ❑ Enrique G. Molina, MD
- ❑ Marcus Muehlbauer, MD
- ❑ Yaseen B. Perbtani, DO
- ❑ Shea O. Ross, MD
- ❑ Charles A. Sninsky, MD
- ❑ Renata Wajsman, MD

- ❑ This referral is URGENT!
- ❑ Consultation
  Reason for referral: _____
- ❑ Patients pertinent medical records are included with this fax

Services provided by DDA:

- ✓ *Colonoscopy*
- ✓ *Upper Endoscopy*
- ✓ *Sigmoidoscopy*
- ✓ *EUS*
- ✓ *ERCP*
- ✓ *Hepatitis Therapy*
- ✓ *Infusion Therapy*
- ✓ *Hemorrhoid Banding*
- ✓ *Colon/Small Bowel Capsule*
- ✓ *Fibroscan*

Practice Name _____ Physician Name _____

Practice Address _____ City/State/Zip _____

Practice Phone Number _____ Practice Fax Number _____

Office Contact (In case we have any questions _____

Direct Messaging Address: _____
If applicable

Once scheduled, patients will receive an email or text message link for their patient information.

Date referral received: _____

1st _____ Entered by: _____

2nd _____ Patient Number: _____

3rd _____ Appt. Date/Time: _____

Thank you!

Thank you for trusting DDA with your patients care. We will notify your office when this appointment is scheduled.