Midwest GI Health

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Scheduling Office:
Received by: _____
Date: ____/____/____

FAX REQUEST FOR CONSULT/PROCEDURE

**If your patient has not heard from us within 2 days of faxing this referral form,
Please have the patient call our office at 816-836-2200**

Patient First Name: _____

Patient Last Name: _____

DOB: ____ /____ /____ Main Phone #: ____- ____ -____ 2nd Phone #: ____- ____-____

PLEASE CHECK ONE (REQUIRED):

☐ OFFICE CONSULT
☐ PROCEDURE: EGD / COLON / HEMORRHOID RX
☐ URGENT - SEE MEDICAL RECORDS

REASON FOR REFERRAL:

DX:

REFERRING INFORMATION

PROVIDER: _____
PHONE #: _____
FAX #: _____
CONTACT PERSON: _____
☐ Check if you wish to receive a confirmation fax.

Scheduling Office: *Staff Initials:* _____

Appt./Procedure Date: ____ /____ /____ Time: _____
Location: _____
Provider: _____

3601 NE Ralph Powell Rd
Lee's Summit, MO 64064

FAX: 816-836-2244

THANK YOU FOR YOUR REFERRAL!

PLEASE SEND DEMOGRAPHICS, INSURANCE CARDS & MEDICAL RECORDS

We cannot schedule your patient's appointment without **THIS FORM** (filled out completely), recent office notes, recent labs or x-rays, demographics and a copy of the patient's insurance card(s).

POS Reorder # 2100386