

GI Referral Form



Referring Provider: _____ Office Contact: _____ Date: ____ / ____ / ____

Referring Office Phone: _____ Referring Office Fax: _____

Patient Information

Patient Name: _____ DOB: ____ / ____ / ____

Home Phone #: _____ Cell Phone #: _____

Referral for: Office Consult Colonoscopy Upper Endoscopy (EGD)

Reason for Referral: _____
(Diagnosis or Symptoms)

Referred to: Benjamin Shepard, DO Chad Sisk, DO Winter Wilson, DO
 Deone Walls, CRNP 7938 AL HWY 69, Suite 310 Jessica Howard, CRNP
2525 US HWY 431, Suite 220 Guntersville, AL 35976 55 Rowe Drive, Suite C
Boaz, AL 35957 Tel: (256) 571-8600 Guntersville, AL 35976
Tel: (256) 840-4840 **Fax: (256) 571-8640** Tel: (256) 571-8810
Fax: (256) 840-4844 **Fax: (256) 571-8880**

Please Attach: Patient Demographic Record, including insurance info
 Most current office note
 Most recent Lab results
 Recent diagnostic imaging (CT or US)

**If your patient's needs
are emergent, please
call the office directly.**

MSNA OFFICE USE ONLY

Patient Scheduled Shepard / Sisk / Wilson
Date / Time of Scheduled Visit: _____ Walls / Howard
Thank you for your referral! We appreciate the opportunity to participate in your patient's care!

Patient NOT Scheduled Shepard / Sisk / Wilson
Reason: _____ Walls / Howard
Thank you for your referral! However, we have been unsuccessful in scheduling this patient. Please contact the patient for appropriate follow-up. Feel free to call our office with any questions.

Attempt Contact Log: 1. _____ 2. _____ 3. _____
Date / Time Date / Time Date / Time

Completed By: _____ Date Faxed to Referring Physician: ____ / ____ / ____