Gastroenterology Department-Jacksonville

1000 Brabham Avenue, Jacksonville NC 28546

Phone: 910-989-4862 Fax: 910-341-1900

Patient Referral Form for **Dr. Joseph Gallagher**

Please carefully complete referral form before a referral can be made

Patient Last Name: _____ MI: ___ First: _____ DOB: _____

Address: _____ _____

Number and Street City, State & Zip

Home phone: _____ Cell #: _____ SS#: _____

Insurance-(Copy of Insurance Cards Requested). Please list all insurances or include copies of front and reverse of all insurance cards.

Primary: _____ #: _____

Secondary: _____ #: _____

Authorization Required Yes: ___ No: ___ Authorization #: _____ Contact: _____

Group NPI #: _____ Referring MD: _____ NPI#: _____

Address: _____ Phone: _____ FAX: _____

Primary Care Provider: _____ UPIN #: _____

Reason for Referral: Consult: ___ Colonoscopy: ___ EGD: ___ Other: _____

Specific questions you would like addressed in this consultation:

****REQUIRED WITH REFERRAL: Copy of Insurance Cards, Office notes/OP notes and X-Ray/MRI/CT reports. **Have patients bring all films to appointment**

Please allow several business days for records to be processed before the appointment can be made.

We have contacted your patient and scheduled this appointment.

Appointment Date: _____ Time: _____AM / PM

Prep date prior to procedure: _____ Time: _____ AM / PM

Revised: 3/14/16, 3/27/17