CMCL Gastroenterology
2600 W. Pleasant Run Rd.
Lancaster, TX 75146
Ph: 888.817.7143
Fax: 888.776.1348

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (888)776-1348

Referring Provider: _____ Referring Office Name: _____

Referring Provider Phone #: _____ Office FAX #: _____

Primary Care Provider: _____ Today's Date: _____

Person Completing Form: _____ Patient's SSN: _____

Patient's Name (F/MI/L): _____

Patient's Address: _____

Patient's Date of Birth: _____ Patient's Phone #: _____

Patient's Insurance/Auth #'s: _____

Reason for Referral (please be specific): _____

_____

_____

_____

Please Note:

☐ Please include most dates: Colonoscopy _____, EGD _____

Provider: _____ (Please attach reports)

☐ Please include most recent progress notes, lab results, pathology reports, CT reports, and procedure reports.

☐ Please include any additional information pertinent to this referral.

☐ We will notify the patient by mail and phone of appointment time and date

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only
Provider: _____
Appointment Date: _____
Appointment Time: _____

Version 12-27-2018