Bhatti GI
CONSULTANTS, P.A.

PHYSICIAN REFERRAL FORM

Date:_____

OFFICE CONSULTATION	**COLONOSCOPY**	**ERCP**
UPPER ENDOSCOPY	**FLEXIBLE SIGMOIDOSCOPY**	**EUS**
LIVER BIOPSY	**CAPSULE ENDOSCOPY**	

INTENT OF THIS REQUEST IS: _____

REFERRING PHYSICIAN: _____

CLINIC CONTACT NAME/PHONE # _____

Patient Information

PATIENT NAME and DOB _____

DAY/CELL PHONE # _____

Please use the link below to forward this form to our office or feel free to print and send to our office by either email or fax. We will contact your patient immediately. Also, please attach any chart notes relavant to this patient's care.

Phone: (952) 368-3800
Fax: (952) 368-3801
Web: www.bhattigi.com

Thank you for putting your trust in us. We will take extra measures to give the best possible care for your patient. If you have further questions or concerns, feel free to contact us.

BHATTI GI
sbhatti@bhattigi.com

****Please send demographics and insurance information**