WVUMedicine

UNITED HOSPITAL CENTER

UHC Gastroenterology
527 Medical Park Drive, Suite 402
Bridgeport, WV 26330
681.342.3690 Phone
681.342.3695 FAX

Eduardo Castillo, M.D.
David A. Ciarolla, M.D.
Kimberly Fairley, D.O.
Tomas Rodriguez-Molinet, M.D.
Venu Gangireddy, M.D.
Brittny N. Gudalis, PA-C

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-3695

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:
EPIC MRN:
Appointment Date:
Appointment Time:

Version 09-23-2016